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Regular Items

Housing Expenditures of the Elderly: Owners and Renters

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Housing is of paramount economic importance to elderly households. It represents a substantial portion of the net worth of owners. Also, housing expenses are the highest category of expenditures for elders. Using the 1990 Consumer Expenditure Survey, this paper describes out-of-pocket expenditures by elderly owners and renters with a special analysis for widows who are often faced with the decision of whether or not to sell their home. Results indicated that elderly homeowners allocate 32 percent of expenditures to housing; renters spend 43 percent. Housing expenses are not significantly different for owners and renters. Elders and their financial advisers cannot assume that selling a house and renting an apartment will lower housing expenses.

Nearly four of five elderly households own their home, and their home equity is a substantial portion of their net worth (40 percent, on average) (*2*). Also, the money spent for maintenance, utilities, taxes, insurance, rent, and other housing expenses is usually the largest expenditure of the households, surpassing food, transportation, and health care (*3*). In addition to economic considerations, housing has importance to the elderly because it may be basic to their independence, social networks, and general lifestyle.

The American Association of Retired Persons reports that studies show "most older people want to stay put." Seventy percent of older people do not move after they reach their 65th birthday (*1*). Indeed, community programs emphasize "aging in place." Services such as meals on wheels, home chores, and home health care programs are designed to make it possible for people to stay in their homes. Equity conversion plans, such as reverse mortgages, are economic tools for the elderly who need access to their home equity but wish to remain in their homes.

The costs of living in these homes, that is, the out-of-pocket expenditures, are presented in this paper. Expenditures on housing and other goods and services are reported for owners and renters who are age 65 or older. In addition, a subgroup of widows is highlighted. The housing expenditures of elderly widows living in single-family, detached houses that they own are compared with those of widows living in rented apartments.

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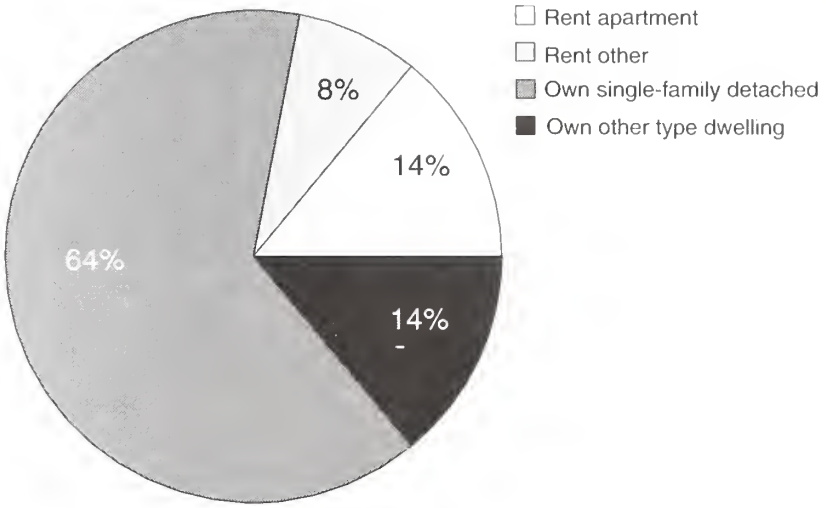
Data

Data for this study are from the interview component of the 1990 Consumer Expenditure Survey (CE), conducted by the Bureau of the Census for the Bureau of Labor Statistics. The CE is an ongoing survey that collects data on household expenditures, income, and major socioeconomic and demographic characteristics. A national sample of consumer units[1] is interviewed once each quarter for five consecutive quarters; the first interview is used only for bounding purposes. Using a rotating sample design, about one-fifth of the sample is replaced each quarter. The 1990 CE, with a response rate of 86 percent, contains information from about 20,000 interviews. Quarterly expenditure data are multiplied by four to provide estimates of annual expenditures.

For this study, consumer units that had a reference person or spouse 65 years or older were selected. This sample of 4,363 units was weighted to represent the 21 million elderly consumer units in the Nation. The subsample of widows included 590 women who owned a single-family, detached house and 263 women who rented a high-rise, flat, or garden apartment.

[1]A consumer unit consists of either: (1) all members of a particular household who are related by blood, marriage, adoption, or other legal arrangement; (2) two or more people living together who pool their incomes to make joint expenditure decisions; or (3) a person living alone or sharing a household with others or living as a roomer in a private home or lodging house or in permanent living quarters in a hotel or motel, but who is financially independent. To be considered financially independent, at least two the three major expense categories (housing, food, and other living expenses) have to be provided by the respondent.

Figure 1. Percentage of elderly consumer units, by housing tenure and type of dwelling, 1990



Who Owns Their Home?

Elderly households may own or rent their home—a detached house, duplex, apartment (high-rise, flat, or garden), mobile home, or other dwelling. Seventy-eight percent own their homes (figure 1). They have equity; in fact, 80 percent of owners do not have a mortgage.

These data are presented two ways: home ownership rates by socioeconomic and demographic characteristics are shown in table 1, p. 4, and the same characteristics as a percentage of owners and renters are shown in table 2, p. 5. The two tables provide different views of the same data.

First, table 1 shows that family type and marital status are related to home ownership. About two-thirds of women or men who live alone are homeowners, whereas 90 percent of husband-wife families are homeowners. Marital status distinguishes home ownership among those who are not married. Seventy-one percent of widows and widowers, 61 percent of never-married people, and 56 percent of divorced and separated people are homeowners. Those in the younger age ranges are more likely to be homeowners (85 percent of those ages 65-69 compared with 69 percent of those ages 80 or older). In the older age groups, renters may once have been owners. They may have sold their home for equity conversion or reasons related to location or maintenance. White households have a higher rate of home ownership than other races. Education is also related; those with some college education are more likely to be homeowners.

In addition to characteristics of the family, characteristics of the dwelling affect home ownership. Detached homes and mobile homes are nearly always owned when lived in by elders; 94 percent of detached homes and 92 percent of mobile homes are owned, not rented. About half of town houses and 2-, 3-, or 4-plexes and about one-quarter of apartments are owned. Rural elderly families are more likely than urban families to be homeowners; 87 percent of rural units, compared with 76 percent of urban units, own their home.

The mean total expenditures for owners is more than half again that for renters....Even so, housing expenses are only slightly higher for owners...

Table 2 describes the characteristics of owners and renters and the type and location of dwellings that are owned and rented. Over half of the owned units are owned by husband-wife families, whereas over half of the rented units are occupied by females living alone, often widows. The age category with the largest proportion of owners is 65-69 years; one-third of owners are this age. Among renters, the largest proportion is 80 years or older; one-third of renters are in this age category. A larger proportion of owners than renters had college experience; 28 percent of owners, 18 percent of renters. Eighty-two percent of owned units are single-family, detached houses; 62 percent of rental units are apartments. Eighty-two percent of owned units and 91 percent of rented units are in urban areas.

Mean expenditures for housing, and the subcategories of shelter and utilities; household operations; and furnishings and equipment are shown together with expenditures for other categories of goods and services. Shelter for owners includes mortgage interest,[1] property taxes, insurance, and repairs and maintenance expenses. Shelter for renters includes rent and tenants' insurance. Since utilities are often included in the rent, it is not possible to separate utilities from shelter. Therefore, they are combined for both renters and homeowners. Household operations include personal services, laundry and cleaning supplies, postage, and similar expenses. Services for housekeeping, gardening, and care of invalids are part of household operations. Furnishings and equipment include textiles, furniture, floor coverings, and appliances.

[1]In the CE survey, mortgage principal is considered to be an investment, not consumption, so is not included as a housing expenditure.

Table 1. Percentage of elderly[1] households that own their home, 1990

Characteristic	All units 65+
Sample size	4,363
Population (in millions)	21
	Percent
All	78
Family type	
Husband and wife	90
Female living alone	65
Male living alone	61
Other	83
Marital status	
Married	90
Widowed	71
Divorced, separated	56
Never married	61
Age (years)	
65 - 69	85
70 - 74	79
75 - 79	77
80+	69
Race	
White	79
Black	73
Other	63
Education	
Not high school graduate	76
High school graduate	77
Some college	84
Type of building	
Single family, detached	94
Town house, duplex	51
High-rise, flat, garden apartment	23
Mobile home	92
Location	
Rural	87
Urban	76

[1]Reference person or spouse 65 years or older.

What Are Housing Expenditures of Owners and Renters?

Housing expenditures of elderly owners and renters reflect housing preferences and choices that result from their family composition, age, education, and other socioeconomic and demographic factors as well as the market differences (prices, tax aspects, interest rates, availability) of owning or renting. The housing expenditures of each group are shown in table 3, p. 6. These are out-of-pocket expenses so do not include opportunity costs, such as the return if the equity were invested elsewhere.

The mean total expenditure for owners is more than half again that for renters ($18,613 for owners; $11,852 for renters). Even so, housing expenses are only slightly higher for owners ($5,875 for owners; $5,112 for renters). Because 80 percent of owners had no mortgage, their shelter costs were mostly property tax, homeowners' insurance, and repairs and maintenance. Owners' expenditures for household operations and furnishings are more than twice as high as renters', but they are minor shares of the housing expenditure.

Although the difference in housing expenditures is modest, owners spend more than twice as much as renters for transportation and more than 1-1/2 times as much for food and health expenses (figure 2). Housing expenditures account for 32 percent of owners' total expenses but 43 percent of renters' expenditures.

Table 2. Characteristics of elderly consumer units,[1] by housing tenure, 1990

Characteristic	Own	Rent
Sample size	3,377	986
Population (in millions)	16.3	4.5
	Percent	
Family type		
Husband and wife	53	21
Female living alone	27	54
Male living alone	8	17
Other	12	8
Marital status		
Marrried	55	23
Widowed	35	50
Divorced, separated	7	19
Never married	3	8
Age (years)		
65-69	34	22
70-74	26	25
75-79	21	23
80+	19	30
Race		
White	90	87
Black	9	11
Other	1	2
Education		
Not high school graduate	45	53
High school graduate	27	29
Some college	28	18
Type of building		
Single family, detached	82	19
Town house, duplex	5	16
High-rise, flat, garden apartment	5	62
Mobile home	8	3
Location		
Rural	18	9
Urban	82	91

[1]Reference person or spouse 65 years or older.

What Are Housing Expenditures of Widows Living Alone?

Because many widows consider whether or not to sell their house and move to a smaller apartment, housing costs of widows who own a single, detached house and those who rent an apartment are shown on table 3. The two types of buildings were chosen because most widows who own a dwelling own a single, detached house (78 percent) and most widows who rent a dwelling rent an apartment (72 percent). It cannot be assumed that owners would spend as renters do if they sold their houses and became renters because they differ in other characteristics. A longitudinal study that followed the housing costs of women who owned and then rented would be needed. Yet, there are interesting comparisons. The owners have slightly larger total expenditures (15 percent higher), but their housing expenditures are not significantly different (using t-test comparisons of widowed owners and renters). Housing accounted for 41 percent of total expenditures for these widowed owners and 47 percent for widowed renters.

Those who are in houses have more living space. The owners have 5.7 rooms (2.6 bedrooms, 1.2 baths), compared with 3.4 rooms (1.3 bedrooms, 1.0 baths) for renters. Widowed owners are also purchasing more services, but renters may pay for some of these services as part of their rent. Owners spend an average of $247 per year for gardening services (compared with $1 for renters' gardening services) and $78 for care of invalids (compared with $5 for renters). Owners and renters spent about the same for housekeeping services, $68 and $69, respectively.

Figure 2. Expenditure shares for elderly consumer units, by housing tenure, 1990

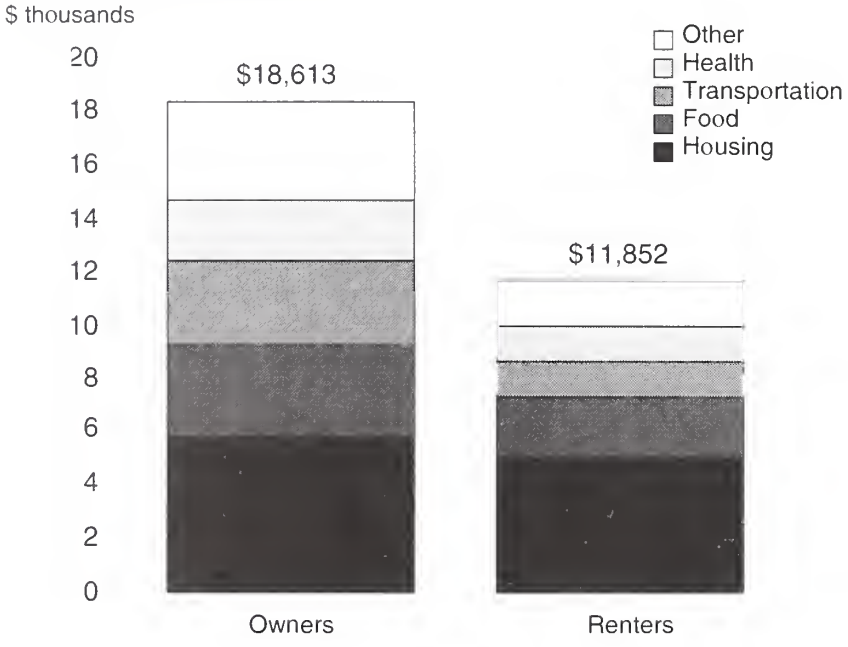


Table 3. Mean housing expenditures of elderly consumer units, by housing tenure, 1990

	All 65+[1]		Widow 65+ living alone	
Expenditure	Own[2]	Rent[2]	Own house[3]	Rent apartment[4]
Total expenditures	$18,613	$11,852	$11,977	$10,410
Housing	5,875	5,112	4,955	4,892
Shelter and utilities	4,828	4,686	4,040	4,547
Household operations	437	188	475	118
Furnishings/equipment	610	237	440	229
Food	3,514	2,295	1,970	1,911
Transportation	3,191	1,353	1,387	897
Health	2,301	1,342	1,565	1,291
Apparel	694	358	462	362
Entertainment	782	303	344	223
Personal care	254	150	191	169
Reading, education	205	104	208	124
Miscellaneous	1,797	835	895	541

[1] Reference person or spouse 65 years or older.
[2] Own or rent detached house, apartment, or town house, duplex, mobile home, other.
[3] Own detached single-family dwelling.
[4] Rent high-rise, flat, or garden apartment.

Conclusions

Two major conclusions may be made from this study. First, elderly consumers —whether homeowners or renters— spend a large portion of their total expenditures on housing. Elderly homeowners allocate 32 percent and renters allocate 43 percent to housing.[2] An even greater percentage of total expenditures was spent on housing by widows who live alone and rent an apartment, 47 percent. This leaves little money for other goods and services and does not allow for much flexibility in spending.

[2]The share for all consumer units is 31 percent (*3*).

Second, it cannot be assumed that selling a house and moving to a small apartment will lower housing expenses. On average, renters paid as much in out-of-pocket expenses (including shelter, utilities, and furnishings) for their apartments as owners did for their larger houses. It does liquidate the equity, however, which may be the primary goal.

Each person's situation is different so elderly householders must evaluate their particular housing options. Communities and policymakers may assist by providing a variety of housing alternatives for the elderly so that they may choose housing that best fits their needs and resources. For some, this may be maintaining the home they own.

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Trends in Consumer Credit

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Consumer credit plays an important role in the U.S. economy. As measured by the Board of Governors of the Federal Reserve System, outstanding installment credit has increased as a percentage of disposable personal income, from 7.1 percent in 1950 to 18.5 percent in 1990. By the third quarter of 1992, this percentage had dropped to 16.6 percent. This decrease may reflect the rise in home equity loans outstanding, which are not measured in consumer installment credit statistics. Automobile financing is the largest component of consumer credit; credit card accounts, however, are increasing at the fastest rate. An estimated 70 percent of U.S. families, up from 50 percent in 1970, have at least one credit card. In 1990, bank cards and general-purpose cards accounted for 58 percent of consumer revolving credit outstanding. Credit card interest rates, sources of consumer credit, selected studies on the use of credit, the creditor's view of credit and credit scoring, and related legislation are presented.

This article presents an overview of trends in consumer credit. From a historical perspective, various developments in consumer credit are described. Types of credit available to consumers, changing patterns in the use of credit, and direct and indirect costs of credit—to consumers, merchants, and creditors—are discussed.

The concept of credit has existed for over 3,000 years; people were using credit before they were using money (*23*). Future crops or labor could be pledged in return for current food or shelter needs.

Once, borrowing in order to purchase nonessential consumer goods was considered unacceptable. Buying on credit was a practice to be avoided whenever possible. Today, however, there is little or no stigma attached to buying on credit (*25*). Creative applications of credit use have been developed over the years to make borrowing even more convenient—overdraft provisions, for example (*23*).

Consumer credit has become increasingly important to the U.S. economy (*14*). By making acquisition easier, demand for goods and services is stimulated and the economy is boosted. For the individual family, however, monthly installment payments reduce financial resources for regular expenses as well as savings. This raises the level of vulnerability to financial emergencies (*27*).

In 1945, consumer installment debt of the average American family amounted to 2 percent of its annual income (*3*). For the next 10 years, outstanding consumer debt increased by an average of 20 percent per year, reflecting (1) demand for goods and services unavailable during World War II; (2) the beginning of the baby boom; (3) an increasingly liberal attitude toward credit; and (4) a rapid growth in availability of credit (*3*).

Credit expansion has moderated since then except during 1977-78 and 1983-85 when annual increases exceeding 15 percent occurred (*3*). Annual growth in consumer installment and revolving credit end-of-year balances averaged 9 percent over the period 1981-90 (table 1). Revolving credit balances, as a share of total consumer installment, grew from 19 percent to 30 percent over the 10-year period (*5*).

As a percentage of disposable personal income, outstanding installment credit increased from 14.5 percent in 1981 to 18.5 percent in 1990 (*5*), then decreased to 16.6 percent in the third quarter of 1992 (*15*). Forty years earlier, in 1950, this ratio had been 7.1 percent; in 1960, 12.3 percent; and in 1970, 14.7 percent (*17*).

Automobile financing has been the single largest component of consumer credit,[1] but credit card accounts are the most rapidly expanding segment (figure 1, p. 10). Recent data indicate that automobile credit outstanding fell at an annual average rate of 4 percent from 1989 to 1992, after increasing at an average annual rate of 6 percent from 1987 to 1989 (*15*). Auto leasing has become more popular with consumers because monthly payments, based on only a portion of the total value of the car, are lower than with a traditional auto loan. Of total passenger cars delivered in 1992, 24 percent were leased, compared with 12 percent in 1986 (*15*).

[1]Not only have automobile loans increased in amount financed, the typical loan period has increased from 3 to 4 to 5 years, and the downpayment percentage has decreased (*23*).

Table 1. Consumer installment and revolving credit outstandings: 1981-90

Year	Consumer installment credit[1]		Revolving credit as a percent of installment credit
	Year-end balances (million $)	Payments as a percent of disposable personal income	
1981	335,691	14.5	19.2
1982	355,849	14.2	19.7
1983	383,701	14.3	21.4
1984	460,500	15.6	22.1
1985	535,098	17.3	22.1
1986	577,784	18.4	23.4
1987	613,022	18.6	26.0
1988	659,507	18.6	26.5
1989	716,624	18.7	27.5
1990	739,014	18.5	29.5

[1]Includes automobile loans, mobile-home financing, revolving credit, and other.

Source: Calem, P.S., 1992, The strange behavior of the credit card market. Business Review. January-February issue (5); Canner, G.B. and Luckett, C.A., 1991, Payment of household debts, Federal Reserve Bulletin 77(4):218-229 (8); and other Federal Reserve Bulletins.

Credit Cards

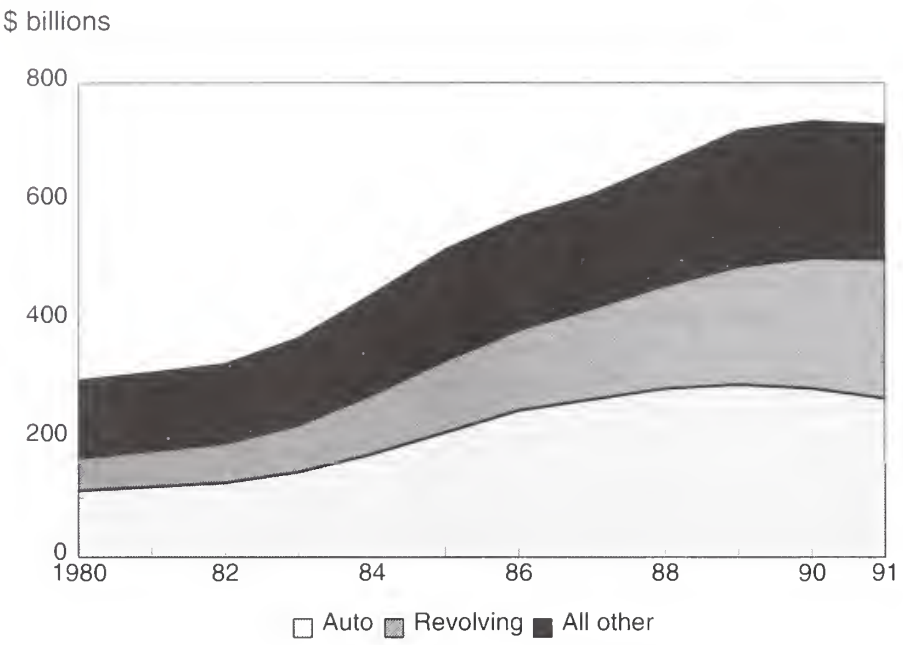
When our society was less mobile, local merchants knew their customers and extended credit according to past experience. As the consumer began dealing with merchants over a larger geographic area, this personal trust had to be replaced with an established third-party guarantor. The answer was the credit card (*23*).

There are two types of credit cards: a two-party or retail card provides credit for purchases from the issuer, typically a gasoline company or retail establishment; and a general-purpose or bank card, which may be used to purchase goods and services from any merchant who accepts the card. In addition to Visa and MasterCard systems, issuers of general-purpose cards include AT&T, American Express, and Sears (*5*).

Although bank cards may be substituted for retail cards, in most cases retail cards cannot be substituted for bank cards. In recent years, various organizations have promoted affinity cards among their members. These are bank cards that bear the logo of the organization—a club, university, labor union, professional association, or business (*5*).

It has been estimated that 70 percent of U.S. families, up from 50 percent in 1970, have at least one credit card account (*7*); 2 of 3 have at least one retail card (*5*); over half have one or more Visa cards; and almost half have at least one MasterCard (*5*). In 1990, bank cards and general-purpose cards accounted for 58 percent of consumer revolving credit outstanding, compared with 51 percent in 1981 (*5*). The average number of accounts held by all cardholding families, in 1989, was nearly six (*7*).

Figure 1. Consumer credit outstanding



Source: U.S. Department of Commerce, Bureau of the Census, 1992, Statistical Abstract of the United States, 1992, [112th ed.] (26).

Convenience Users and Installment Users

According to Mandell (*23*), "With a credit card you can buy yourself a new car. Without it, you cannot even rent one." Credit cards serve two primary functions: a means of payment and a source of credit. People also use credit cards as a means of identification and to order goods and services by telephone, such as airline tickets (*7*). People may choose to use credit cards rather than pay cash because cash may not be available; it may be convenient not to carry cash; savings may result from buying now and paying later; and it simplifies recordkeeping (*29*).

Convenience users of credit cards regard them as a method of payment and typically pay the balance in full each month. About one-third of credit card users are convenience users (*5,7,20*). Installment users consider credit cards as an alternative method of financing and choose to carry a balance from month-to-month in spite of the interest penalties.

Choosing an economically appropriate credit card requires that the consumer knows how the credit card will be used and has made a comparison of credit card costs (*13*). The best credit card for a convenience user would be one with no annual fee and a long grace period; for an installment user, the best card has a low interest rate (*7,13*).

Interest Rates

Credit card interest rates have been relatively stable for many years. Some consumers discourage banks and retailers from reducing their rates: convenience users who don't incur interest charges and don't respond to rate reduction and poor credit risks who are very likely to respond to lower rates because they fully intend to borrow, thus increasing the probability of losses through default (*19*). Also, consumers may regard the search and switch costs as too high. These costs include the time and effort to identify a more attractive card and to complete an application, potential consequence of having a credit rejection added to a credit bureau report, possibility of lower credit limit with a new issuer, uncertain quality of service, and uncertain future rates and fees (*7,19*).

During the past 2 years, however, credit card interest rates have been falling (*11*). A study conducted for the General Accounting Office found that nearly 40 percent of credit cardholders paid less than 16.5-percent interest on their cards. Two years earlier, 9 percent of cardholders reported such rates.

This reduction in rates can be attributed to the many new nontraditional issuers (such as General Motors and General Electric Corporations) that want to build relationships with their cardholders; they are willing to offer better rates to accomplish this purpose. In turn, traditional issuers have also lowered their rates in response to this competition and a heightened consumer awareness: Other loan rates have fallen, consumer interest is no longer tax-deductible, and credit cards are competing with home equity lines of credit.

Home Equity Loans as a Source of Consumer Credit

Home equity loans include the traditional closed-end loan (a second mortgage) that typically requires repayment of interest and principal in equal monthly installments and the home equity line of credit—a revolving account that allows flexibility in borrowing and repaying (*6,9*). Both types of home equity loans enable homeowners to borrow against the equity in their homes.

The home equity line of credit has become a more popular source of credit among consumers since the Tax Reform Act of 1986 eliminated the deductibility of interest paid on nonmortgage consumer credit (*9*). In 1986, a typical home equity lender had a median of about $14 million outstanding in home equity loans and lines of credit. In 1991, the median amount outstanding in home equity closed-end loans was $52 million and, in home equity lines of credit, $79 million (*15*).

Banks and other lending institutions have aggressively marketed the home equity line of credit. Interest rates have been markedly lower than for most other types of consumer credit, especially credit cards. Most lenders set a maximum line of credit equal to 70 to 80 percent of the homeowner's equity; the equity is considered to be the appraised value less any mortgage or liens against the property (*6*). There is usually a minimum credit line (frequently $5,000) and, of course, a maximum (around $100,000). Most lenders allow homeowners to access their line of credit by check; others may permit telephone transfers or provide access through automatic teller machines or credit cards. There may be a minimum amount for each draw on the credit line.

Finance rates are usually variable and adjusted monthly. Most are based on the prime rate, adding a fixed margin.

The Competitive Equality Banking Act of 1987 requires all home equity accounts established after December 9, 1987, to have an interest rate ceiling for the life of the account. The act does not specify any maximum or minimum rate or restrict changes in interest rates (*6*).

Many lenders offer a low introductory interest rate; after a specified period, the rate increases to one that is determined by a formula set forth in the contract, usually an index plus margin. Other promotional offers may include rebating of initial fees, such as origination fees, closing costs, property appraisal, credit report, title insurance, and mortgage recording fee (*6*).

The majority of home equity accounts have a set term, usually 10 to 15 years; many, however, have indefinite terms. Usually, there are no restrictions or penalties on repayment of outstanding balances at any time. Minimum payments can be a fixed dollar amount, a certain percentage of the outstanding balance, or only the interest due. If the loan is not fully amortized, the borrower will owe a balloon payment (*6*).

In summary, major advantages of home equity lines of credit are:

- For the borrower—lower interest rates and deductibility of interest.
- For the lender—building a long-term relationship with the borrower who may need other banking services and a relatively low risk of default because loans are secured by the borrower's home.

...70 percent of U.S. families, up from 50 percent in 1970, have at least one credit card account...

Refinancing a Mortgage

In recent years, homeowners have often refinanced their mortgage to obtain lower interest costs on the existing principal (*9*). Others have refinanced for a longer term in order to reduce their monthly payments. In a 1989 survey of over 1,500 households, sponsored by the Federal Reserve Board, nearly 60 percent of those who refinanced also borrowed additional funds (*9*). This accumulated home equity may be used to finance the purchase of goods and services or to repay other debts. Uses of equity liquidized through refinancing are shown in table 2. On average, consumers who liquidize equity during refinancing access about 25 percent of their accumulated equity (*9*).

According to Canner, Fergus, and Luckett (*6*), statistical models designed to project growth in consumer and mortgage credit indicate that consumers, in the late 1980's, shifted from consumer credit vehicles to a form of mortgage equity loan but did not increase their total borrowing to any great degree.

Table 2. Uses of liquidized equity, by type of loan, 1988-89

Use	Home equity lines of credit		Traditional home equity loan	Refinancing resulting in liquidized equity
	Initial draw	All other draws[1]		
	Percent[2]			
Home improvement	38	58	45	46
Repayment of other debts	40	28	35	36
Education	11	20	1	3
Real estate	10	2	16	17
Auto, truck	7	30	5	5
Medical	3	16	0	2
Business	4	7	6	8
Vacation	1	11	0	2
Other[3]	11	23	5	7

[1]One-third of account users made no drawdown after the original one.
[2]May add to more than 100 percent because multiple uses could be cited for a single loan or drawdown and because a number of draws could be cited for one line of credit.
[3]Includes purchases of furniture or appliances, tax payments, personal financial investments, and purchases of boats or other recreational vehicles.

Source: Canner, G.B. and Luckett, C.A., 1990, Mortgage refinancing, Federal Reserve Bulletin 76(8):604-612 (9).

Selected Studies on Credit Use

Eugeni observed trends in consumer installment credit and compared them with trends in home equity borrowing and automobile leasing. She concluded that consumer borrowing patterns have changed: home equity borrowing has been substituted for other types of credit and auto leases are partly replacing traditional auto loans. Therefore, the most commonly used debt ratio (consumer installment credit to disposable personal income) understates consumer indebtedness (*15*).

Fan, Chang, and Hanna developed a model of optimal credit use with uncertain future income. Their analysis showed that both the rate of real income growth and the probability of real income growth are critical determinants of the rational use of credit for current consumption. Families and individuals at the early stages of the family life cycle are more likely to find borrowing to be a rational choice, as income tends to increase until retirement (*16*).

Chang and Hanna found that although education had a positive effect on the probability of search, most consumers (80 percent) did not consider searching for information before purchasing credit (*10*). However, size of loan and education level had positive effects on the probability of search.

According to Sumarwan and Hira, older money managers (compared to younger) and those from households with higher monthly income (compared to those from lower income households) used a smaller proportion of their monthly income to make installment payments (*27*).

Danes and Hira determined there was a negative relationship between knowledge of credit cards and age of the money manager; this relationship was positive for education level and household income level (*12*). The same study found that people who use a high number of credit cards and who often accumulate finance charges have a higher knowledge about credit cards. Respondents with high levels of credit card knowledge believe credit cards should be used more for installment purchases than for convenience.

A study by Wasberg and others found that age of money manager, income, total assets, and amount of credit card debt with which the manager was comfortable tended to be more significant predictors of monthly payments and total debt than credit card practices. Credit card usage—number of cards—was not associated with greater consumer debt (*29*).

Lindley and others studied changes in credit card possession and use over time. They concluded that since **growth** in new holders of credit cards appears to be declining but credit card use appears to be increasing, current holders of credit cards are the best market for additional credit cards (*21*).

A 4-year study conducted by the University of Michigan's Survey Research Center in the late 1960's found that attitude towards debt was related to debt/income ratio. Families with highly favorable attitudes reported credit levels twice as high as did those with highly unfavorable attitudes. Also, attitudes differed by stages of the family life cycle. Families with children were most likely to feel okay about borrowing, followed by older couples without children. Older single people were least likely to have a favorable attitude towards borrowing (*17*).

A later study, using data from the Survey of Consumer Finances, corroborated this family life-cycle effect. Highest median amounts of credit card debt were reported by families with a head less than 54 years old (those most likely to have children living at home) (figure 2). A higher percentage of these same families reported credit card debt than did older families (figure 2a). Family income had a greater effect on median credit card debt than on the likelihood to carry any such debt (*18*).

Figure 2. Median credit card debt of families carrying such debt, by age of family head and family income, 1989

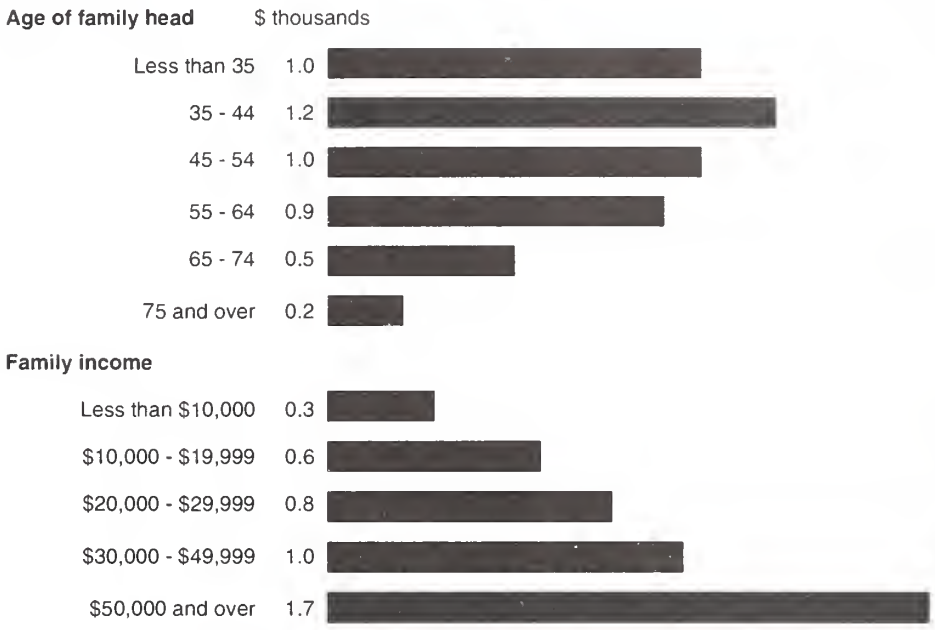


Figure 2a. Percentage of families carrying credit card debt, by age of family head and family income, 1989

Source: Kennickell, A. and Shack-Marquez, J., 1992, Changes in family finance from 1983 to 1989: Evidence from the Survey of Consumer Finances, Federal Reserve Bulletin 78(1):1-18 (15).

The Credit Card Industry Perspective

In 1979, only 71 percent of banks offered MasterCard or Visa. By 1985, 90 percent offered a Visa and 87 percent offered a MasterCard. Banks held nearly two-thirds of total credit card outstanding balances in 1986, up from one-half in 1982 (*23*). Holders of consumer installment credit are shown in figure 3.

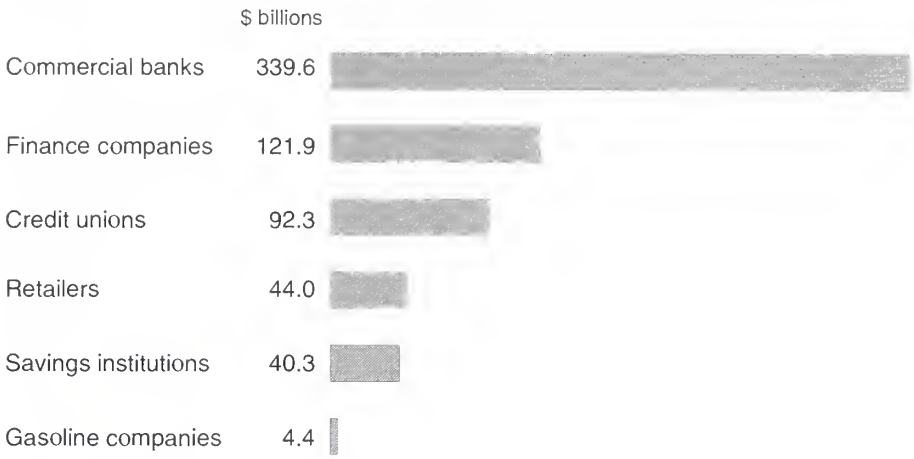
In 1992, there were about 6,000 commercial banks and other depository institutions that marketed general-purpose (mostly Visa or MasterCard) credit cards. Another 12,000 depository institutions act as agents for issuers and distribute credit cards to consumers (*7*). Competition among banks and companies such as AT&T, American Express, and Sears has made it more difficult and more expensive to sign up new accounts.

Marketers of credit cards seek to gain new accounts (*1,26*) by offering the consumer:

- Fair fees—a low annual percentage rate, or no annual fee
- Increased credit limit
- Customer service—extended warranties on purchases, car rental collision insurance
- Cash advance checks
- Skip-payment option
- Cash back bonus or rebates
- Coupons and sweepstakes
- Or they try to buy a competitor's credit card portfolio.

Credit card issuers earn money three ways: fees charged to customers, charges assessed to merchants on each purchase, and interest from outstanding credit balances. About 70 percent of

Figure 3. Consumer installment credit,[1] by holder, 1991



[1]Includes most short- and intermediate-term credit extended to individuals that is scheduled to be repaid (or has the option of repayment) in two or more installments.

Source: Board of Governors of the Federal Reserve System, Federal Reserve Bulletin, 1993, Table 1.55 (4).

Citicorp's and Chase Manhattan's net profits come from credit cards (*26*). Earnings from fees and charges paid by merchants are not sufficient to cover costs. Substantial interest charges are also needed to compensate for convenience users who pay little or no finance charges (*7*). Bank cards lost money or were only marginally profitable until the 1980's when interest rates were allowed to rise (*23*).

Credit extended through credit cards is unsecured.[2] Losses on credit cards (including those from fraud) have been higher than losses on other types of credit (*7*). A majority of these losses (56 percent in 1987) result from nonpayment (*23*).

[2]Some lenders will grant credit to people with poor credit histories if they deposit money in a savings account that serves as collateral and usually pays passbook rate of interest (*7*). Technically, this type of credit card is secured.

Credit Scoring

Credit scoring systems have been used by institutions for many years to predict whether credit applicants will repay on schedule (*2,22*). Statisticians develop sophisticated models that assign numerical values to certain characteristics of applicants that have been shown to be effective predictors. Models can be modified and used for scoring installment loans, mortgage loans, and auto loans in addition to credit card accounts. The best (most successful in predicting) models are both product- and institution-specific.

Most often, models include factors related to the account (past delinquencies, relation of account balance to credit limit, and the age of the account) and attributes of the borrower (occupation and employment history) (*22*). According to *Money*, common causes of credit rejection include a recent move or new

Credit Card Milestones (*23*)

1914	- Retailers issue credit cards
1930's	- Wanamaker's initiates revolving credit
1949	- Diners Club
1958	- BankAmericard
	Carte Blanche
	American Express
1966	- BankAmericard goes nationwide
1976	- BankAmericard becomes Visa
1979	- J.C. Penney signs with Visa
1980	- Master Charge becomes MasterCard
	Citibank purchases Diners Club
	Annual credit fees initiated
1985	- First affinity cards from Visa and MasterCard
1986	- Sears launches Discover Card
1990	- AT&T Universal Card[1]

[1]Date when first offered was provided in a fact sheet distributed by AT&T Universal Card Services Corp.

job, too many credit inquiries, owing 80 percent or more of your credit limits on two or more cards—or owing anything on four or more cards, and if credit payments plus mortgage or rent exceeds 35 to 45 percent of before-tax income (*24*). Factors that are predictive in one area of the country may not be in another (*22*).

Lenders with mainframe computer capabilities can interview a prospective borrower, key in the responses, and then have the system check for fraud, duplicate applications, and acceptable debt ratio. Usually this entire process takes less than 10 minutes (*2*).

Other types of scoring used by banks and other lenders include:

- Behavior scoring—evaluates and monitors current accounts. When should credit limits be raised—or lowered?
- Collection scoring—identifies the likelihood that a specific customer will become seriously delinquent within a given time (*2*).

Selected Legislation Related to Consumer Credit

Congress has enacted a series of laws designed to aid and inform consumers entering into credit transactions (*14*). Federal protection of consumer borrowing began in 1968 with the Consumer Credit Protection Act. Title I of this legislation is known as the Truth in Lending Act. This act requires creditors to disclose the important terms of consumer credit contracts, thereby enabling consumers to make better decisions regarding credit use. The act further states that rates quoted to consumers either orally or in writing must be true annual percentage rates (APR's). Also, consumer credit advertising must follow certain guidelines.

The Fair Credit Reporting Act of 1970 requires that the consumer be told and be given the name and address of the credit bureau whose report was used when information in that report is used as a basis for a creditor's decision to deny, eliminate, or reduce a line of credit (*22*). The consumer is entitled to obtain a free copy of the credit report, and, if the information is incorrect, the consumer has a right to request that the matter be investigated and the information corrected.

The Equal Credit Opportunity Act of 1974 prohibits creditors from discriminating against credit applicants or existing customers on the basis of race, color, religion, gender, or marital status (*22*). As long as the consumer is not currently delinquent or in default, lenders must notify the consumer within 30 days of an adverse action—terminating a credit card or reducing the established credit line.

The Fair Credit and Charge Card Disclosure Act of 1988 requires card issuers to disclose credit terms on applications and in solicitations (*5,12*). Terms include the annual percentage rate, fees, grace period, and balance calculation method associated with the credit card (*13*). Before this law was passed, consumers often did not learn the credit terms on their card accounts until after their applications were approved and they had received a credit card accessing the account (*19*). The law also establishes rules with regard to advertising: creditors that mention specific costs in advertisements must also disclose other relevant cost information. In contrast, if creditors advertise that certain fees are *not* charged on an account, no additional disclosures are required (*19*).

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A Profile of Nursing Home Users Under Age 65

The appropriate use of nursing homes is a matter of national concern. The Omnibus Budget Reconciliation Act of 1987 established screening procedures for all residents of Medicaid-certified facilities to determine, through a combination of mental illness and physical health criteria, whether residents should be reassigned to other facilities more appropriate to their needs. Federal financing arrangements may sometimes encourage the use of nursing homes when other types of care would be more appropriate: because Medicaid does not pay for home care, household chore services, or for modifications to a home or special equipment that would allow a disabled individual to live independently, many individuals are forced into skilled-care facilities even though this level of care and supervision is not necessary.

The number of nursing home residents under age 65 is expected to grow for several reasons. The parents of disabled people born during the baby boom period are aging and may no longer be able to provide the informal care required by their disabled offspring. Individuals born with developmental disabilities or those who have experienced serious trauma are surviving because of medical advances but will increasingly require long-term care. Also, individuals with AIDS will more likely require long-term care services as the course of the disease lengthens.

This report uses data from the Institutional Population Component of the 1987 National Medical Expenditure Survey (NMES) to characterize people under age 65 who spent at least one night in a nursing home in 1987. The NMES Institutional Population Component is composed of national, representative samples of residents of nursing and personal care homes and facilities for the mentally retarded.

Data were collected in three phases and four interviews. Data on resident characteristics were obtained from a baseline questionnaire administered to staff responsible for direct patient care or other designated staff. Facility data were obtained from a facility questionnaire. Respondents were facility administrators or designated staff.

A facility is considered a nursing or personal care home if it is certified by Medicare or Medicaid or is a separate place or unit of another institution licensed or officially recognized by a State. Personal care assistance is defined to be nursing or medical care; supervision of medications; and help with bathing, dressing, walking, eating, correspondence, or shopping.

About 10 percent of all nursing and personal care home users were under age 65 (table 1). Nearly 5 percent were between the ages of 18 and 54, and about 6 percent were ages 55 to 64. The number of men and women in these age groups was evenly distributed, in contrast to the population 65 years and older where 72 percent were women (table 2, p. 20). In 1987, about 20 percent of nursing home users between ages 18 and 54 were black. In the older age groups, this proportion declined to 11 percent for the 55 to 64 age group, and to 6 percent for the 65 and older group.

More than 56 percent of nursing home users ages 18 to 54 had never been married; this likely reflects the type of health problem that led to institutionalization. In contrast, 33 percent of those ages 55 to 64 had never been married. Only 13 percent of nursing home users ages 65 and over had never been married.

The regional distribution of nursing home users differed by age as well. The age group 18 to 54 was evenly divided between the Northeast, the Midwest, and the South (29 percent each), with only 13 percent found in the West. This finding may reflect differences in both the availability of nursing home beds and in program incentives in the West such as MediCal, which encourage disabled individuals to remain in the community. The regional distribution of nursing home users in the age group 55 to 64 showed a higher proportion of residents in the Midwest (31 percent) and the South (30 percent) than in the Northeast (20 percent) and the West (19 percent). A similar regional distribution was observed among the elderly user population.

More than 36 percent of nursing home users 18 to 54 years of age had disorders of the central nervous system, such as multiple sclerosis, cerebral palsy, paralysis, and epilepsy; 34 percent suffered from psychoses; 34 percent were afflicted by nonpsychotic mental disorders; and 24 percent had mental retardation.

Diseases of aging, such as ischemic heart disease and hypertension, were reported in 24 and 26 percent of nursing home users ages 55 to 64. At 37 percent for each, psychoses and nonpsychotic mental disorders were the most prevalent conditions in the age group 55 to 64. Disorders of the central nervous system were reported in only 21 percent of this age group.

Table 1. People in nursing and personal care homes, by age, United States, 1987

Age (in years)	Number (in thousands)	Percent
Total population	2,235	100.0
Under 65	231	10.3
18 to 54	106	4.7
55 to 64	125	5.6
65 and older	2,004	89.7

Source: Agency for Health Care Policy and Research, National Medical Expenditure Survey—Institutional Population Component.

Among nursing home users ages 65 and older, nearly 45 percent suffered from psychoses, most likely dementia. Nonpsychotic mental disorders were found at rates similar to other age groups. Elderly users also suffered from diseases of the arteries (38 percent) and arthropathies (32 percent), which include rheumatoid arthritis and osteoarthritis.

Twenty-six percent of those ages 18 to 54 had difficulties in activities of daily living (ADL's)—such as bathing, dressing, transferring from a bed or chair, toileting, and feeding oneself—but no mental disorders or mental retardation; 23 percent were without ADL limitations but had one or more mental disorders or mental retardation; and 24 percent had a high number of ADL limitations in addition to mental disorders and/or mental retardation. In the group ages 55 to 64, over 14 percent had only a mental disorder and no evidence of ADL difficulties; 30 percent suffered from ADL limitations (with or without a mental disorder). A majority of elderly nursing home users had high levels of ADL limitations (63 percent), many in combination with mental disorders (37 percent).

Thirty-two percent of nursing and personal care home users between the ages of 18 and 54 had been admitted to their resident facility from independent living in the community; 16 percent had been transferred from another nursing home; and 40 percent came from a hospital or other health care facility. The rest came from retirement homes, group homes, boarding houses, or the street. Of nursing home users 55 to 64 years old, 27 percent came from their home, and 53 percent came from a hospital or other health care facility. For users ages 65 and over, 44 percent had been living independently in the community and 40 percent transferred from a hospital. Elderly users were most likely among the three age groups to have come to the nursing facility from their home.

Nursing home users ages 18 to 54 had been institutionalized longer (6.3 years) than residents ages 65 and older (4.8 years). Only 10 percent of elderly users had been institutionalized for 10 years or more, compared with 20 percent of the group ages 18 to 54.

Table 2. Selected characteristics of people in nursing and personal care homes: Percent by age, United States, 1987

Characteristic	Ages 18 to 54	Ages 55 to 64	Ages 65 and older
Total population (in thousands)[1]	106	125	2,004
		Percent of users	
Sex			
Male	50.0	46.5	28.2
Female	50.0	53.5	71.8
Racial background			
White	77.4	86.4	92.0
Black	19.8	10.8	6.4
Marital status			
Married	14.3	25.5	18.0
No longer married[2]	26.8	41.1	68.8
Never married	56.5	30.9	12.5
Census region			
Northeast	28.6	20.5	22.3
Midwest	28.9	30.9	31.4
South	29.2	29.5	29.1
West	13.2	19.0	17.3
Facility ownership			
For profit, independent	22.3	22.6	24.3
For profit, chain	45.0	50.2	44.7
Nonprofit, independent	13.0	7.7	15.5
Nonprofit, chain	8.2	8.3	7.4
Public	11.4	11.2	8.2
Bed size			
3 - 49	15.1	12.6	9.8
50 - 99	16.4	27.2	25.6
100 - 149	27.8	27.7	33.0
150 or more	40.8	32.6	31.5
Certification status			
Skilled nursing and intermediate care facility	41.8	39.3	44.6
Skilled nursing facility only	17.6	21.4	24.2
Intermediate care facility only	17.4	25.5	21.2
Not certified	22.9	13.6	10.0
Place of residence			
Independent living in the community	32.4	27.5	44.0
Facility for the mentally retarded or nursing home	15.6	11.2	10.5
Hospital/health care facility	40.3	53.2	40.4
Other[3]	11.7	8.1	5.1

[1]Includes all other racial groups and people of unknown marital status.
[2]Widowed, separated, or divorced.
[3]Includes retirement homes, boarding houses, group houses, correctional facilities, training centers, or the street; and all other facility types not shown separately.

Source: Agency Health Care Policy and Research, National Medical Expenditure Survey—Institutional Population Component.

Expenditures for nursing home users ages 18 to 54 were an aggregate $1.6 billion in 1987, compared with $26.1 billion for elderly users. Nearly half of aggregate nursing home expenditures for elderly patients was paid by the elderly themselves or through family support. For those 18 to 54 years old, 20 percent was paid out of pocket and, for those 55 to 64 years old, 27 percent. Of the total expenditures for nursing home users, Medicaid paid 72 percent for patients ages 18 to 54, 53 percent for those ages 55 to 64, and 45 percent for those ages 65 and over. The Department of Veterans Affairs paid about 8 percent of nursing home expenditures for users 55 to 64 years of age, in contrast to about 1 percent for both of the other age groups.

The severity and nature of the illnesses afflicting young nursing home users and their age-specific social and psychological needs present the long-term care system with a different set of challenges than those of the typical elderly user. Given both the nature and variability of the nursing home population by age and on other dimensions, further research is needed to inform policymakers regarding the expected demands and special needs of institutionalized people of all ages.

Source: Lair, T., 1992, *A Profile of Nursing Home Users Under Age 65*, National Medical Expenditure Survey Research Findings 13, Agency for Health Care Policy and Research, Public Health Service, AHCPR Pub. No. 92-0060.

Economic Implications of Rising Health Care Costs

This study, conducted by the Congressional Budget Office (CBO) at the request of the House Committee on Ways and Means, examines the effects of rising health care costs on the economy—on workers, businesses, and governments. It also looks at the implications of providing health insurance through an employment-based system. In keeping with the CBO's mandate to provide nonpartisan analysis, the report does not include recommendations.

The CBO predicts that spending on health care in the United States will rise from 12 percent of gross domestic product (GDP) in 1990 to 18 percent by the year 2000, an increase as large as that between 1965 and 1991. Total national spending on health care includes estimates of spending by the private sector as well as by government. On the Federal level, health spending is the only category of the budget, with the exception of net interest, that is rising as a share of GDP. At the State level, increases in Medicaid costs will make it more difficult to fund other programs or provide tax relief. Compared with other industrialized countries, the United States spends a much greater proportion of GDP on health than would be expected from its per capita income—without gaining a substantially healthier population.

There are two main reasons why growth in the health care sector is a cause for concern. First, most U.S. consumers are not concerned with costs when they need major medical attention because they are covered by health insurance. Second, because most consumers know little about medicine, they trust health care professionals to make health care decisions for them.

Most of the growth in health care spending in the United States seems to come from a persistent upward trend in per capita spending for health services. This is especially true for hospitals' and physicians' services, which together make up about 60 percent of total national health spending. However, measurement problems make it difficult to distinguish between the rising prices for medical care and the rising quality of care.

The growth in health care costs imposes substantial pressures on government budgets. Medicare and Medicaid, the Federal Government's health care entitlement programs, are the fastest growing portion of its budget. Spending on these programs has grown from about 1 percent of GDP in 1970 to 3 percent in 1991, and is expected to rise to 6.1 percent by the year 2002. Increases in health costs will lead to larger Federal budget deficits if lawmakers do not enact legislation to finance these expenditures.

Rising health care costs exert similar pressures on the budgets of State and local governments. Because almost all States have balanced budget agreements, increases in health spending will have to be financed by raising revenues or cutting public services.

Rising health care costs place significant burdens on American workers. These rising costs have absorbed much of the growth of employees' real compensation over the past two decades.

Table 1. Payment sources for national health care expenditures as a share of total for selected years, 1960-90

Source	1960	1965	1970	1975	1980	1985	1990
				Percent			
Private	75.5	75.3	62.8	58.5	58.0	58.6	57.6
Out of pocket	49.2	45.7	34.4	29.0	23.8	22.3	20.4
Health insurance	21.7	24.0	22.5	24.8	29.3	31.7	32.5
Other	4.6	5.5	5.9	4.8	4.8	4.6	4.6
Government	24.5	24.7	37.2	41.5	42.0	41.4	42.4
Federal	10.7	11.6	23.9	27.4	28.8	29.2	29.3
State and local	13.8	13.2	13.3	14.1	13.3	12.1	13.1

Source: Congressional Budget Office based on data from Health Care Financing Administration.

Together with the slow growth of productivity, the rising costs for health insurance explain why workers' cash wages have hardly grown during this period.

The market for health care is different from other markets. Consumers of health care are often in no position to shop around and usually lack information upon which to base their choices of treatment. As a result, many of these choices are made by doctors and other health professionals who are taught to provide the best possible care—not the most cost-effective care. Because quality health care is so important to the consumer and because most costs are not paid out of pocket, neither the consumer nor the doctor is likely to pay much attention to the overall costs of treatment at the point of service. Furthermore, physicians can earn more income by providing more care, which may also contribute to excessive spending.

The medical care market is also different from other markets because the government subsidizes health care, allowing some consumers greater access to medical care than they would otherwise have. In addition to Medicare and Medicaid, employment-based health insurance may be considered a major subsidy because it is not considered taxable compensation under the tax code. This significantly reduces the effective cost of the insurance and encourages people to buy more health insurance—and perhaps more medical care—than they otherwise would.

Development and use of new and expensive medical technologies, such as innovative diagnostic procedures and new drugs, have raised the overall costs of health care. Insurance coverage means that these advances have a ready market among consumers and health care providers.

Table 2. Health insurance coverage for U.S. population under age 65, by source of coverage, 1990

Insurance coverage	People under age 65	
	Number (millions)	*Percentage of total*
Population under age 65	216.7	100.0
Insured	183.5	84.7
Source of coverage[1]		
Private insurance		
Employment-based	150.5	69.5
Other	14.6	6.7
Medicaid	14.6	6.7
Medicare	3.0	1.4
Veterans Administration	0.8	0.4
Not insured	33.1	15.3

[1]Refers to the individual's primary insurance coverage when there are multiple sources of coverage.

Source: Congressional Budget Office calculations based on data from the Current Population Survey, March 1990.

In 1960, consumers paid out of pocket for about half of all health care expenditures. By 1990, they paid for only about one-fifth (table 1, p. 21). Health insurance effectively removes the incentives for patients to seek out low-cost providers, or for physicians to be cost conscious on their patients' behalf. Other factors such as demographic changes, rising personal income, and higher medical malpractice costs are sometimes blamed for increasing the Nation's health care bill, but they probably do not contribute significantly to the increases.

In 1990, about 70 percent of the population under age 65 was covered by health insurance received through an employer (table 2). Although the employment-based health insurance system seems to provide workers with insurance at exceptionally low costs (employers generally pay most of the premium), in the long run employers' costs are largely shifted back to workers in the form of lower real wages and reduced nonmedical benefits. Rising health care costs and minimum-wage laws have encouraged employers who offer health plans to move low-wage workers to part-time status with no coverage, or replace them with contract workers.

Employers dominate the market for supplying health insurance because employers can offer coverage at lower costs than alternative suppliers. Four factors account for this cost advantage:

- Federal and State tax code—employer-sponsored health insurance can be deducted by employers as an expense, but it is not taxed as income to the employees. Also, the portion of health insurance paid by the employer is not counted in the wage base for the purpose of calculating payroll taxes.
- Lower administrative costs—the fixed costs of setting up and administering an insurance policy for a group are spread among many people, resulting in reduced average per-person costs.

- Reduced adverse selection—this is the tendency for an insurance plan to attract individuals with medical needs that an insurance company cannot detect. Employment-based insurance policies can reduce adverse selection by limiting the easy entry and exit of policyholders from the insurance pool. In addition, employers may impose waiting periods before a new employee is eligible for insurance and establish personnel policies that reduce employee turnover.
- The benefits of a healthy work force—healthy workers spend less time on sick leave and may be more productive on the job, lowering real costs of insurance to employers.

Rising health care costs cause more and more Americans to be uninsured. In 1990, 33 million people under the age of 65 did not have health insurance. By the year 2000, CBO predicts that number will grow to almost 40 million. In the current employment-based system, many people are uninsured because (1) employers do not have to offer health insurance and employees do not have to take it; (2) insurance companies are increasingly using rating and underwriting policies that exclude high-risk people; and (3) people with limited income may not be able to afford health insurance, relying on the subsidized medical care provided in the emergency rooms of public hospitals. Workers without health insurance tend to work for small companies (table 3), have low incomes, few skills, and unstable jobs, and tend to be young.

If the projected increases in Federal health spending are not offset by increases in taxes or cuts in other Federal spending, rising health care costs will mean a larger budget deficit. A larger deficit reduces the Nation's overall level of saving, which slows the rate of capital accumulation, increases our indebtedness to foreigners, and reduces the competitiveness of American industry. If policymakers could stabilize health costs in relation to GDP, the outlook for medium-term economic growth and competitiveness would be much brighter.

There is enormous interest in reforming the entire U.S. system of delivering medical care in the hope of cutting its cost and extending its reach. However, health care reform could mean less spending on research and development; longer waiting times for access to new technologies; and limitations on existing choices of providers, health insurance coverage, and treatment alternatives. Whether these trade-offs are acceptable depends on the priority that the country places on controlling costs rather than maintaining the other characteristics of the health care system.

Source: Congress of the United States. Congressional Budget Office, 1992, *Economic Implications of Rising Health Care Costs.*

Table 3. Availability of employment-based health insurance plans, by size of firm, 1989

Number of employees in firm	Percentage of firms offering plans	Percentage of employees covered by those plans
0 to 9	33	42
10 to 24	72	70
25 to 99	94	94
100 to 499	99	97
500 to 999	100	100
1,000 and over	100	100
All firms	43	77

Source: Congressional Budget Office based on data from 1989 Employer Survey by Health Insurance Association of America.

Private Health Insurance Premiums in 1987: Policyholders Under Age 65

This report, prepared by the Public Health Service's Agency for Health Care Policy and Research, presents preliminary estimates of health insurance premiums and sources of payment in 1987. The data were obtained from the Health Insurance Plans Survey (HIPS) and the Household Survey of the 1987 National Medical Expenditure Survey (NMES). The NMES, a nationally representative survey of the civilian noninstitutionalized population, is designed to provide a larger representation of population groups of special policy interest to the Federal Government than would have been obtained from a random sample. These groups include poor and low-income families, the elderly, the functionally impaired, and Black and Hispanic minorities. The HIPS component obtained premium data from employers, unions, and insurance carriers.

In 1987, $153 billion was spent on health insurance premiums for policyholders under the age of 65 and their dependents. Employers contributed 77 percent of this total, policyholders paid 20 percent, and other payers such as labor unions and professional associations contributed the rest. On average, 1987 health insurance premiums were $2,606 for family coverage[1] and $1,042 for single coverage.

Most people (86 percent in 1987) who are privately insured receive their health insurance through the workplace. Employer contributions toward health insurance are not taxed as income, which reduces the effective price of employment-related insurance. People who receive untaxed employer contributions toward their insurance thus have an advantage over those who purchase insurance directly from an insurance company or association with after-tax dollars. Also, workers with higher incomes and higher marginal tax rates receive a greater benefit from the tax-exempt status of employer contributions than do those with lower incomes.

There are several reasons why health insurance premiums vary in cost. First, employment-related insurance and insurance offered to members of professional or similar associations are usually provided as group insurance, with more comprehensive benefits and less cost sharing than its nongroup counterpart. Second, premium expenses for family coverage were about 2.5 times the cost of single coverage in 1987. Third, differences in administrative costs create variation in premiums that are typically related to the size of the group covered. Other factors, such as medical underwriting for particular individuals and for small groups, also contribute to the variation in premiums.

[1]Family coverage includes all multiperson coverage, including policyholders with both single and family coverage.

Table 1. Private health insurance premiums for policyholders under age 65 with single coverage plans, by family income, United States, 1987

Family income of policyholder	Number of policyholders (in thousands)	Total annual premiums	Total annual out-of-pocket expense	Total annual employer contributions
			Mean	
Total	31,171	$1,042	$263	$755
$10,000 or less	2,692	919	404	507
$10,001 - $20,000	7,131	1,021	283	714
$20,001 - $30,000	6,068	1,043	251	769
$30,001 - $40,000	4,605	1,082	294	758
$40,001 - $50,000	3,431	1,096	200	875
$50,001 - $75,000	4,131	1,042	230	792
$75,001 or more	3,115	1,075	186	853

Source: Agency for Health Care Policy and Research, National Medical Expenditure Survey—Health Insurance Plans Survey and Household Survey.

Table 2. Private health insurance premiums for policyholders under age 65 with family coverage, by family income, United States, 1987

Family income of policyholder	Number of policyholders (in thousands)	Total annual premiums	Total annual out-of-pocket expense	Total annual employer contributions
			Mean	
Total	46,199	$2,606	$478	$2,026
$10,000 or less	1,581	2,338	683	1,553
$10,001 - $20,000	5,179	2,457	505	1,832
$20,001 - $30,000	7,808	2,539	523	1,889
$30,001 - $40,000	8,457	2,597	518	2,010
$40,001 - $50,000	7,072	2,655	433	2,087
$50,001 - $75,000	10,235	2,688	435	2,168
$75,001 or more	5,868	2,710	413	2,208

Source: Agency for Health Care Policy and Research, National Medical Expenditure Survey—Health Insurance Plans Survey and Household Survey.

Variation in out-of-pocket premium expense reflects whether or not the insurance is sponsored by an employer. The great majority of policyholders with insurance that is not employment-related pay the full premium costs, whereas about 50 percent of individuals with employment-related insurance pay nothing toward their coverage.

Employers contributed an average of $755 toward the cost of single coverage in 1987, and out-of-pocket premium expenses averaged $263 (table 1). Nearly one-half (49 percent) of policyholders paid nothing out of pocket toward the cost of their coverage. Of those with income of $10,000 or less, 30 percent paid nothing toward their coverage, compared with 58 percent of those with income over $75,000.

Of single-coverage policyholders with income of $10,000 or less, 59 percent had contributions from their employer, compared with 86 to 90 percent for those with income over $40,000.

Employer contributions averaged $507 for policyholders in the lowest income group, compared with $714 to $875 for other policyholders.

Policyholders with family coverage averaged $478 in out-of-pocket premium expenses in 1987 (table 2). Forty-three percent of these policyholders paid nothing out of pocket toward their coverage. Policyholders with family incomes of $10,000 or less paid $683 out of pocket for their family coverage, compared with $413 to $435 for policyholders with family incomes above $40,000.

Employers contributed an average of $2,026 toward the cost of family coverage. A higher proportion of policyholders with family coverage (90 percent) received help from employers in paying for their health insurance than did those with single coverage (82 percent). However, those with family coverage were less likely than those with single coverage to have policies paid for entirely by employers or other sources (43 and 49 percent).

The distribution of health insurance premiums should be useful to analysts and policymakers in assessing the potential implications of changes in the tax treatment of health insurance premiums.

Source: Vistnes, J., 1992, *Private health insurance premiums in 1987: Policyholders under age 65*, National Medical Expenditure Survey Data Summary 5, Agency for Health Care Policy and Research, Public Health Service, AHCPR Pub. No. 92-0061.

Projections of National Health Expenditures

Spending on health care in the United States has increased rapidly in recent decades, placing considerable pressure on both private and public budgets. This report reviews the growth in national health spending since 1965 and provides projections through the year 2000. The study was undertaken by the Congressional Budget Office (CBO) at the request of the House Committee on Ways and Means.

CBO's projections of national health spending assume that government health programs, laws, and regulations do not change over the rest of the decade. The projections also assume that current trends in clinical medical practices and procedures will continue and that there will be no major structural change in the private sector's employer-based health insurance system.

The growth in national health spending can be divided into three distinct periods: 1965 to 1983, when it grew largely unencumbered by policy or financing constraints; 1983 to 1987, when government and private cost-containment efforts temporarily reduced the growth of health spending and the number of uninsured people increased significantly; and 1987 to 1990, when more rapid growth of expenditures resumed. Projections are divided into two periods: 1990 to 1992, a time of recession; and 1992 to 2000, assumed to be a period of relatively stable economic growth.

In 1965, national health expenditures totaled $42 billion. Over the next 15 years, health spending grew at an average annual rate of 12.7 percent and totaled $250 billion in 1980. Total spending on health care is projected to reach about $800 billion in 1992 and nearly $1.7 trillion in 2000. Between 1992 and 2000, spending on health care is expected to grow at an average annual rate of 9.6 percent, almost 4 percentage points faster than the projected gross domestic product (GDP) growth of 5.8 percent.

Despite the weak economy of the last 2 years, employment and incomes in the health sector of the economy have increased significantly. The total number of jobs in the health sector increased by 639,000 from May 1990 through May 1992, while the number of nonhealth jobs fell by 2.4 million. The average net income[1] of physicians ($164,000 in 1990) grew at an annual growth rate of 6.6 percent between 1982 and 1990, compared with a growth rate of only 4.3 percent a year for all full-time workers during the same period. Similarly, community hospital[2] margins (the net of revenues less expenses) were 5.2 percent in 1991, higher than their 20-year average of 4.2 percent.

Projections by Type of Spending

Hospital, physician, drug, and nursing home expenditures (all personal health categories) accounted for nearly 75 percent of national health spending in 1990 (table 1). CBO projects that hospital spending will increase at an average rate of 10 percent a year during the 1990's, up from 9.5 percent in the 1980's. Physician services will increase by 9.7 percent, down from 11.6 percent in the 1980's. Spending on drugs is projected to grow by 7.5 percent annually in the 1990's and nursing home care, by 10 percent.

Smaller categories of personal health spending, which accounted for about 16 percent of total national health expenditures in 1990, include dental care, other professional services, home health care, vision products and durable medical equipment, and other personal expenditures. These categories, with the exception of other professional services, are characterized by relatively large proportions of out-of-pocket payments and lower rates of expenditure growth.

Other national health expenditures, which do not apply to direct patient care, include construction and research, investments related to future health care, and certain administrative costs of government programs, public health services, and private health insurance. These other national health expenditures accounted for about 12 percent of total national health spending in 1990 and are expected to grow at an average annual growth rate of 7.7 percent between 1992 and 2000.

Projections by Source of Funds

All health spending eventually comes out of the consumer's pocket through direct payments, higher taxes, and lower wages. Direct patient payments tend to grow much more slowly than payments made by third parties. Relatively slow growth in out-of-pocket payments is consistent with the basic motivation for health insurance—people want to avoid large and uncertain out-of-pocket expenditures.

Out-of-pocket payments by patients, private health insurance payments, and other private payments are projected to decline, as a percent of national health spending, from 58 percent in 1990 to 52 percent in 2000 (table 2).The proportion of national health expenditures paid directly by patients is expected to decline from 20 percent in 1990 to 16 percent in 2000.

[1]Income less office expenses, malpractice insurance premiums, and similar expenses.
[2]The Health Care Financing Administration defines community hospitals as "acute care hospitals whose average length of stay is less than 30 days and whose facilities and services are open to the general public."

Table 1. Projections of National Health Expenditures, by type of spending

Type of spending	Selected calendar years						
	1965	1980	1985	1990	1992[1]	1995[1]	2000[1]
	$ Billions						
Hospital	14	102	168	256	310	416	671
Physician	8	42	74	126	153	204	316
Drugs, other nondurables	6	22	36	55	63	78	111
Nursing home	2	20	34	53	65	87	137
All other	12	64	110	177	218	287	444
Total	42	250	423	666	808	1,072	1,679
	Average annual growth rate from previous year shown (percent)						
Hospital		14.2	10.4	8.8	10.0	10.3	10.1
Physician		11.5	12.0	11.2	10.4	10.0	9.1
Drugs, other nondurables		9.0	10.9	8.6	7.1	7.5	7.4
Nursing home		17.9	11.3	9.3	10.5	10.3	9.5
All other		12.0	11.4	10.0	11.0	9.7	9.1
National Health Expenditure		12.7	11.1	9.5	10.1	9.9	9.4
Gross Domestic Product ($ billions)[2]	703	2,708	4,039	5,514	5,931	7,104	9,322
Average annual growth of Gross Domestic Product (percent)[2]		9.4	8.3	6.4	3.7	6.2	5.6
Ratio of National Health Expenditures to Gross Domestic Product[2]	5.9	9.2	10.5	12.1	13.6	15.1	18.0

[1]Projected.
[2]Economic assumptions reflect the Congressional Budget Office baseline of January 1992.
Note: Details may not add to totals because of rounding.
Source: The Congress of the United States, Congressional Budget Office, 1992, Projections of National Health Expenditures.

CBO foresees that private health insurance benefits will continue to grow rapidly despite a slow increase in the number of people covered and a decline in the proportion of the population covered by private health insurance. On the other hand, Medicare and Medicaid are expected to cover an expanding proportion of the population. Since both are entitlement programs, CBO assumes that under current law, spending for these programs will continue to increase rapidly on behalf of the entitled populations.

Almost all the elderly have guaranteed access to health care through the Medicare program, which pays the bulk of hospitalization costs and offers a heavily subsidized insurance program for physician services and other out-patient care. The Medicaid program, which provides medical services for about one-half of the Nation's poor, is the fastest growing source of funds for national health expenditures. Its share of payments is expected to rise from 11 percent in 1990 to nearly 19 percent in 2000. Recent expansions in eligibility, rising reimbursement rates mandated by the courts, and the weakening of private health insurance account for this increase. Medicaid furnished about 6 percent of the population with their primary coverage in 1991.

Other private payments include hospital nonpatient revenues and philanthropy. Other Federal funding is provided through the Department of Defense, the Department of Veterans Affairs, and the National Institutes of Health. Other State and local health payments include workers' compensation, direct support of public hospitals and school health programs, and public health efforts.

Table 2. Projections of National Health Expenditures, by source of funds

Source of funds	Selected calendar years						
	1965	1980	1985	1990	1992[1]	1995[1]	2000[1]
				$ Billions			
Private	31	145	248	384	441	574	869
Public							
Federal	5	72	124	195	253	343	566
State and local	5	33	51	87	115	155	244
Total	42	250	423	666	808	1,072	1,679
				Percentage of total			
Private	75.3	58.0	58.6	57.6	54.5	53.5	51.7
Public							
Federal	11.6	28.8	29.2	29.3	31.3	32.0	33.7
State and local	13.2	13.3	12.1	13.1	14.2	14.5	14.5
		Average annual growth rate from previous year shown (percent)					
Private		10.8	11.3	9.1	7.2	9.2	8.7
Public							
Federal		19.7	11.4	9.6	13.7	10.7	10.5
State and local		12.8	9.0	11.3	14.7	10.6	9.5
National Health Expenditures		12.7	11.1	9.5	10.1	9.9	9.4

[1]Projected.
Note: Details may not add to totals because of rounding.
Source: The Congress of the United States, Congressional Budget Office, 1992, Projections of National Health Expenditures.

Contributors to Spending Growth

Factors that may account for growth in health care spending are: Population growth, the demographic composition of the population, trends in the per capita use of basic health care services (for example, hospital days and physician visits), overall inflation rates, trends in the relative prices of health services, and the intensity of the services provided.[3] The projected 9.8 percent average annual growth in personal health spending between 1992 and 2000 is based on the combination of increasing prices, expensive new services and procedures, and additional services and procedures per medical contact.

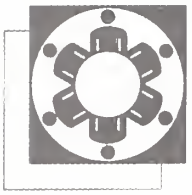
CBO projects relatively slow economic growth during the rest of the 1990's, with low inflation. Under these assumptions, GDP will average real growth of 2.6 percent per year between 1992 and 2000. Population growth, especially that of the elderly, will slow somewhat during the 1990's. The number of people over age 65 will increase 1 percent per year between 1992 and 2000, compared with an average growth of 2 percent per year in the 1970's and 1980's. The share of people over age 85 will continue to grow during the 1990's, increasing the need for nursing home beds. However, States, which pay for a significant amount of nursing home care through Medicaid, have been reluctant to issue permits for new nursing home construction, preventing the number of nursing home beds from keeping up with the demands of the aging population.

In 1990, Medicaid paid for about 45 percent of all nursing home care, and consumers paid for another 45 percent out of pocket.

The share of national health spending by governments is expected to grow during the 1990's. Higher government spending on health care has serious implications for the Federal budget; the projected increase in health care spending outpaces the growth in all other major components of the budget, threatens to preempt resources from other government programs, and makes deficit reduction more difficult.

Source: The Congress of the United States, Congressional Budget Office, 1992, *Projections of National Health Expenditures.*

[3]Intensity can be either extra services provided per contact or more involved, complex, or capital-intensive procedures (such as the use of advanced technolgies) per contact.



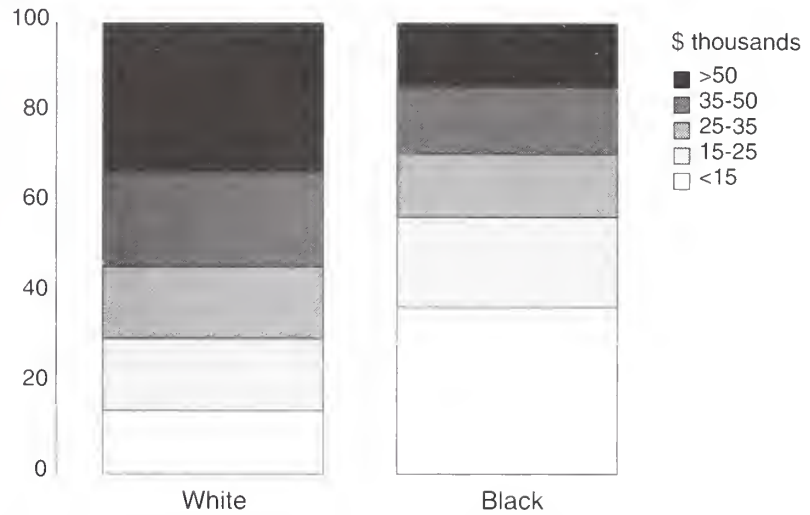
Recent Legislation Affecting Families

Public Law 103-3 (enacted February 5, 1993)—the Family and Medical Leave Act requires businesses to give employees up to 12 weeks of unpaid leave a year for the care of a new baby; the adoption of a child or the placement of a foster child; the serious illness of a child, spouse, or parent; or the employee's own serious health condition. Employees are eligible for this benefit if they have worked for the employer for at least 12 months and for at least 1,250 hours during that period. Employees who work for a business with fewer than 50 employees within a 75-mile radius are excluded. Employees must provide their employers with 30 days' notice when the leave is foreseeable. The law allows employers to require that a request for leave be supported by a health care provider's certification of the medical condition of the employee's child, spouse, or parent. The certification should include a statement that the employee is needed to provide the care, plus an estimate of the amount of time employee will be needed. If the employee is ill, the certification should include a statement that the employee is unable to perform his or her job. Employers are required to maintain health care benefits for employees on leave, and must restore any employee who has taken leave to the position held when the leave began or restore the employee to an equivalent position with equivalent employment benefits, pay, and other conditions. Employers can deny leave to the highest paid 10 percent of workers if such denial is necessary to prevent substantial and grievous economic injury to the business. The law takes effect in August 1993.

Public Law 103-6 (enacted March 4, 1993)—extends the Federal Emergency Unemployment Benefits Program from March 7, 1993, through October 2, 1993. The bill will provide emergency benefits for an extra 20 or 26 weeks, depending on the unemployment rate in the recipient's State, to an estimated 1.5 million workers who have exhausted their State unemployment compensation. The cost, estimated at $5.7 billion, will be paid entirely by the Federal Government.

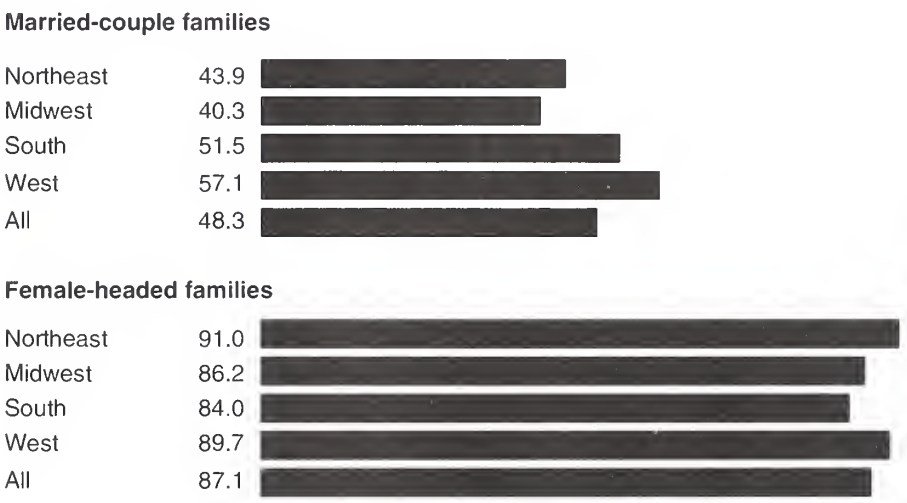
Charts From Federal Data Sources

Distribution of families, by income



Source: Bennett, C.E., 1992, The Black Population in the United States: March 1991, Current Population Reports, Population Characteristics, Series P-20, No. 464, U.S. Department of Commerce, Bureau of the Census.

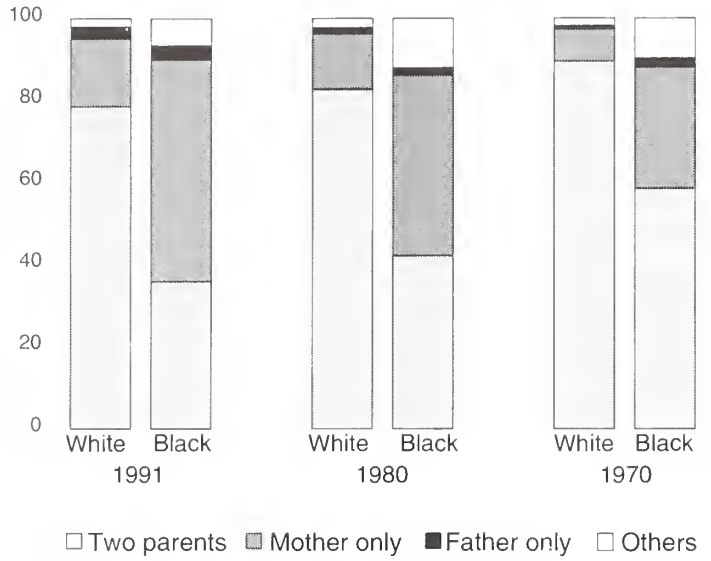
Percentage of householders with children under age 18 who cannot afford a median-priced home[1] in region, 1988



[1]Using conventional, fixed-rate, 30-year financing.

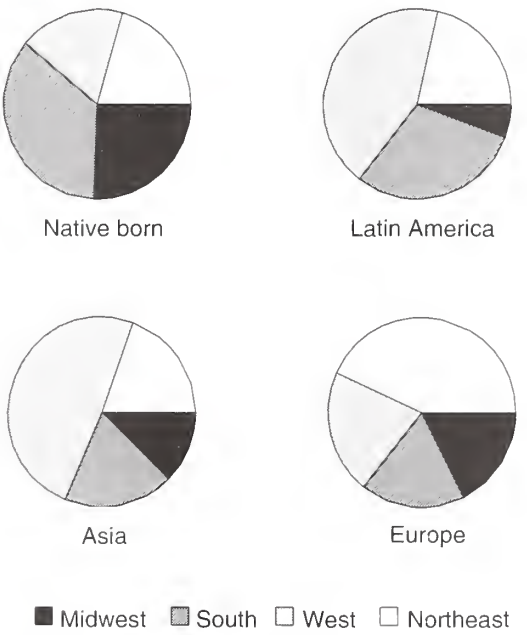
Source: Fronczek, P.J. and Savage, H.A., 1991, Who Can Afford to Buy a House? Current Housing Reports H121/91-1, U.S. Department of Commerce, Bureau of the Census.

Living arrangements of children under 18 years, by race



Source: Saluter, A.F., 1992, Marital Status and Living Arrangements: March 1991, Current Population Reports, Population Characteristics, Series P-20, No. 461, U.S. Department of Commerce, Bureau of the Census.

Distribution of native-born and foreign-born population, June 1988



Source. U.S. Department of Commerce, Bureau of the Census, 1992, Studies in American Fertility, Current Population Reports, Special Studies, Series P-23, No. 176.

Data Sources

National Survey of Families and Households

Sponsoring agency: Center for Demography and Ecology, University of Wisconsin-Madison.

Population covered: People age 19 and older, living in households, and able to be interviewed in English or Spanish.

Sample size: About 13,000 respondents with an oversampling of minorities, one-parent families, families with stepchildren, cohabitors, and recently married couples.

Geographic distribution: Nationwide

Years data collected: 1987-88

Method of data collection: Personal interview and self-administered questionnaire to one adult in the household, with a shorter self-administered questionnaire given to the spouse or partner.

Future surveys planned: A 5-year followup survey is planned.

Major variables: Household composition, household history, marriage and cohabitation history, social background of spouse, marital situation, fertility history and expectations, quality of relationship with children, social and economic characteristics.

Sources for further information and data:

Center for Demography and Ecology
University of Wisconsin-Madison
4412 Social Science Building
1180 Observatory Drive
Madison, WI 53706-1393
(608) 262-2182

1988 National Survey of Adolescent Males

Sponsoring agency: U.S. Department of Health and Human Services

Population covered: Never married, noninstitutionalized American males 15 to 19 years old with an oversampling of Blacks and Hispanics.

Sample size: 1,880

Geographic distribution: The contiguous United States

Years data collected: April-November 1988

Method of data collection: Personal interview (except for sensitive questions, which were asked in a confidential self-administered questionnaire).

Future surveys planned: A followup survey was completed in 1990. Data should be available in late 1993.

Major variables: Over 850 variables focusing on: Education and knowledge about human sexuality, contraception, and sexually transmitted diseases; history of sexual activity, contraceptive use, alcohol or drug use; and socio-economic characteristics.

Sources for further information and data:

Sociometrics Corporation
170 State Street, Suite 260
Los Altos, CA 94022-2812
(415) 949-3282

Journal Abstracts and Book Summary

The following abstracts are reprinted verbatim as they appear in the cited source.

Kingson, E.R. and O'Grady-LeShane, R. 1993. The effects of caregiving on women's Social Security benefits. ***The Gerontologist*** **33(*2*):230-239.**

Using data from the Social Security Administration's 1982 New Beneficiary Survey, we tested a life-course model that suggests that early- and late-life caregiving reduce monthly Social Security benefits of newly retired women workers. Each child raised was associated with a loss of $8 to $16 dollars in the 1983 Social Security primary insurance amounts (PIAs). The 1983 PIAs of women leaving their last jobs to care for others were $127 lower than the PIAs of women who left because of the availability of Social Security benefits, to receive a pension, or because they wanted to retire. Leaving work to care for others exerted a stronger depressing effect on the Social Security benefits of women with low- and moderate- as opposed to high-earnings histories.

McChesney, K.Y. 1992. Absence of a family safety net for homeless families. ***Journal of Sociology and Social Welfare*** **XIX(*4*):55-72.**

Analysis of data from interviews of 80 mothers in five shelters for homeless families suggests that the availability of housing support from kin may be a selection mechanism determining which families become homeless. The availability of kin housing support is seen as a function of four factors: family structure, proximity, control of adequate housing resources, and estrangement. Policy implications are discussed.

Meyer, D.R. and Garasky, S. 1993. Custodial fathers: Myths, realities, and child support policy. ***Journal of Marriage and the Family*** **55(*1*):73-89.**

Men are increasingly receiving custody of their children, and single-father families with children are increasing at a faster rate than even single-mother families. However, many observers still believe that there are few custodial fathers. Indeed, there are a number of myths concerning custodial fathers. We examine three data sets and determine that many of these assumptions about custodial fathers are simply not true. We argue that current child support policies should be reexamined to ensure that they follow the same principles when the custodial parent is the father as when the custodial parent is the mother.

Walden, M.L. 1992. The relative benefits of making a higher down payment or paying points for a lower interest rate. ***Financial Counseling and Planning*****, Vol. 3, pp. 63-77.**

An overlooked decision in homebuying is whether making a higher down payment or paying points to lower the mortgage interest rate is better. This paper outlines the relative costs and benefits of each option and then simulates the options for various mortgage interest rates, lengths of stay, and tax brackets. Internal rates of return are derived as the measure of relative benefit. In typical cases, paying more points to lower the mortgage interest rate is superior to making a larger down payment.

Friedman, M. 1991. ***A "Brand" New Language*****. Greenwood Press, Westport, CT.**

This book brings together a series of studies on changes in language found in the popular literature of the United States since World War II. The studies concern how commercial developments, as indicated by brand names, have permeated the language used in literary works.

Each of the studies is examined in a separate chapter. The final chapter summarizes the major findings of the various studies.

Three measures were used to describe the commercial influence upon language: Frequency and variety of brand names and frequency of generic names. Results of content analyses of popular novels, plays, and songs were consistent: Since World War II, in popular American literature,

- marked increases have occurred in the number and variety of brand names;
- parallel increases have not occurred for generic name usage;
- brands most frequently mentioned represent products high on the dimension of value expressiveness (such as automobiles and magazines).

Estimated Annual Expenditures on a Child by Husband-Wife Families, Lower Income Level, 1992[1]

Age of Child	Total	Housing	Food	Transportation	Clothing	Health Care	Education, Child Care, and Other
U.S. Overall (Income: <$32,100)							
0 - 2	4,630	1,880	690	620	330	270	840
3 - 5	4,970	1,820	780	680	370	250	1,070
6 - 8	4,940	1,820	1,000	730	400	260	730
9 - 11	4,780	1,690	1,130	650	410	270	630
12 - 14	5,500	1,620	1,220	990	670	280	720
15 - 17	5,870	1,600	1,380	1,250	630	300	710
Total	92,070	31,290	18,600	14,760	8,430	4,890	14,100
Urban West (Income: <$32,300)							
0 - 2	4,950	2,210	760	570	320	240	850
3 - 5	5,300	2,190	850	610	350	220	1,080
6 - 8	5,310	2,180	1,080	660	380	230	780
9 - 11	5,180	2,050	1,230	580	390	240	690
12 - 14	5,890	1,980	1,320	920	640	240	790
15 - 17	6,230	1,950	1,470	1,190	600	260	760
Total	98,580	37,680	20,130	13,590	8,040	4,290	14,850
Urban Northeast (Income: <$33,000)							
0 - 2	4,860	2,180	820	520	330	240	770
3 - 5	5,210	2,160	910	560	360	220	1,000
6 - 8	5,230	2,150	1,150	610	390	240	690
9 - 11	5,090	2,010	1,310	530	400	250	590
12 - 14	5,800	1,940	1,390	870	660	250	690
15 - 17	6,160	1,910	1,550	1,140	620	270	670
Total	97,050	37,050	21,390	12,690	8,280	4,410	13,230
Urban South (Income: <$31,600)							
0 - 2	4,730	1,870	690	660	360	300	850
3 - 5	5,080	1,850	780	700	400	270	1,080
6 - 8	5,050	1,840	1,000	760	430	290	730
9 - 11	4,910	1,720	1,140	680	450	300	620
12 - 14	5,620	1,650	1,220	1,020	710	310	710
15 - 17	5,990	1,620	1,370	1,290	670	330	710
Total	94,140	31,650	18,600	15,330	9,060	5,400	14,100
Urban Midwest (Income: <$31,600)							
0 - 2	4,540	1,800	650	580	350	250	910
3 - 5	4,890	1,770	740	620	380	230	1,150
6 - 8	4,850	1,770	950	670	420	240	800
9 - 11	4,670	1,640	1,080	590	430	250	680
12 - 14	5,390	1,580	1,160	920	700	260	770
15 - 17	5,750	1,540	1,310	1,190	660	280	770
Total	90,270	30,300	17,670	13,710	8,820	4,530	15,240
Rural (Income: <$31,700)							
0 - 2	4,090	1,350	580	750	320	290	800
3 - 5	4,430	1,320	670	790	360	260	1,030
6 - 8	4,400	1,320	860	860	390	280	690
9 - 11	4,210	1,190	980	780	400	290	570
12 - 14	4,920	1,130	1,060	1,110	660	300	660
15 - 17	5,270	1,090	1,210	1,380	620	310	660
Total	81,960	22,200	16,080	17,010	8,250	5,190	13,230

[1] Estimates are for the younger child in a two-child family.

Source: USDA, ARS, Family Economics Research Group. 1993. *Expenditures on a Child by Families, 1992.*

Estimated Annual Expenditures on a Child by Husband-Wife Families, Middle Income Level, 1992[1]

Age of Child	Total	Housing	Food	Transportation	Clothing	Health Care	Education, Child Care, and Other
U.S. Overall (Income: $32,100 to $51,900)							
0 - 2	6,610	2,490	870	1,040	430	340	1,440
3 - 5	7,010	2,430	1,000	1,100	460	320	1,700
6 - 8	6,960	2,440	1,270	1,180	500	340	1,230
9 - 11	6,770	2,300	1,430	1,110	510	350	1,070
12 - 14	7,540	2,240	1,510	1,440	840	360	1,150
15 - 17	8,000	2,210	1,680	1,710	790	380	1,230
Total	128,670	42,330	23,280	22,740	10,590	6,270	23,460
Urban West (Income: $32,300 to $52,200)							
0 - 2	6,860	2,800	920	1,000	410	310	1,420
3 - 5	7,280	2,770	1,070	1,040	440	290	1,670
6 - 8	7,290	2,770	1,350	1,130	480	310	1,250
9 - 11	7,120	2,640	1,520	1,050	490	320	1,100
12 - 14	7,880	2,570	1,600	1,390	800	320	1,200
15 - 17	8,300	2,530	1,770	1,660	760	340	1,240
Total	134,190	48,240	24,690	21,810	10,140	5,670	23,640
Urban Northeast (Income: $33,000 to $53,300)							
0 - 2	6,820	2,800	980	950	420	320	1,350
3 - 5	7,250	2,770	1,130	990	450	300	1,610
6 - 8	7,240	2,770	1,420	1,070	490	320	1,170
9 - 11	7,080	2,630	1,600	1,000	500	330	1,020
12 - 14	7,840	2,560	1,680	1,330	830	330	1,110
15 - 17	8,270	2,520	1,850	1,610	780	350	1,160
Total	133,500	48,150	25,980	20,850	10,410	5,850	22,260
Urban South (Income: $31,600 to $51,000)							
0 - 2	6,650	2,430	850	1,090	460	380	1,440
3 - 5	7,110	2,410	1,000	1,140	500	360	1,700
6 - 8	7,040	2,400	1,260	1,230	540	380	1,230
9 - 11	6,840	2,280	1,420	1,150	550	390	1,050
12 - 14	7,610	2,210	1,500	1,490	890	390	1,130
15 - 17	8,090	2,180	1,660	1,760	840	420	1,230
Total	130,020	41,730	23,070	23,580	11,340	6,960	23,340
Urban Midwest (Income: $31,600 to $51,100)							
0 - 2	6,470	2,370	820	1,000	440	320	1,520
3 - 5	6,910	2,340	960	1,050	480	300	1,780
6 - 8	6,820	2,340	1,210	1,130	520	320	1,300
9 - 11	6,610	2,210	1,370	1,050	530	330	1,120
12 - 14	7,400	2,140	1,450	1,390	870	340	1,210
15 - 17	7,880	2,110	1,610	1,660	830	360	1,310
Total	126,270	40,530	22,260	21,840	11,010	5,910	24,720
Rural (Income: $31,700 to $51,200)							
0 - 2	6,020	1,910	740	1,180	420	370	1,400
3 - 5	6,440	1,890	880	1,220	450	340	1,660
6 - 8	6,350	1,880	1,110	1,320	490	360	1,190
9 - 11	6,140	1,760	1,260	1,240	500	370	1,010
12 - 14	6,920	1,690	1,340	1,580	830	380	1,100
15 - 17	7,380	1,660	1,500	1,850	780	400	1,190
Total	117,750	32,370	20,490	25,170	10,410	6,660	22,650

[1] Estimates are for the younger child in a two-child family.

Source: USDA, ARS, Family Economics Research Group. 1993. *Expenditures on a Child by Families, 1992.*

Estimated Annual Expenditures on a Child by Husband-Wife Families, Higher Income Level, 1992[1]

Age of Child	Total	Housing	Food	Transportation	Clothing	Health Care	Education, Child Care, and Other
U.S. Overall (Income: >$51,900)							
0 - 2	9,430	3,730	1,050	1,430	530	420	2,270
3 - 5	9,950	3,670	1,270	1,490	570	400	2,550
6 - 8	9,800	3,680	1,520	1,600	610	430	1,960
9 - 11	9,580	3,540	1,710	1,530	620	440	1,740
12 - 14	10,470	3,480	1,870	1,860	1,000	450	1,810
15 - 17	11,000	3,450	1,970	2,130	950	470	2,030
Total	180,690	64,650	28,170	30,120	12,840	7,830	37,080
Urban West (Income: >$52,200)							
0 - 2	9,620	4,000	1,100	1,400	500	390	2,230
3 - 5	10,160	3,970	1,330	1,440	540	370	2,510
6 - 8	10,040	3,970	1,590	1,560	570	390	1,960
9 - 11	9,850	3,840	1,790	1,480	590	400	1,750
12 - 14	10,730	3,770	1,950	1,820	950	410	1,830
15 - 17	11,210	3,730	2,050	2,100	900	430	2,000
Total	184,830	69,840	29,430	29,400	12,150	7,170	36,840
Urban Northeast (Income: >$53,300)							
0 - 2	9,630	4,050	1,150	1,350	510	400	2,170
3 - 5	10,210	4,030	1,390	1,400	550	380	2,460
6 - 8	10,060	4,020	1,650	1,510	590	400	1,890
9 - 11	9,850	3,880	1,860	1,430	600	410	1,670
12 - 14	10,740	3,810	2,020	1,770	970	420	1,750
15 - 17	11,240	3,780	2,120	2,040	920	440	1,940
Total	185,190	70,710	30,570	28,500	12,420	7,350	35,640
Urban South (Income: >$51,000)							
0 - 2	9,400	3,580	1,030	1,490	570	470	2,260
3 - 5	9,930	3,550	1,250	1,530	620	440	2,540
6 - 8	9,780	3,550	1,500	1,660	650	470	1,950
9 - 11	9,560	3,430	1,690	1,580	670	480	1,710
12 - 14	10,440	3,360	1,840	1,920	1,050	490	1,780
15 - 17	11,010	3,330	1,940	2,190	1,000	510	2,040
Total	180,360	62,400	27,750	31,110	13,680	8,580	36,840
Urban Midwest (Income: >$51,100)							
0 - 2	9,220	3,530	990	1,400	540	410	2,350
3 - 5	9,750	3,500	1,210	1,440	580	380	2,640
6 - 8	9,570	3,500	1,450	1,560	620	400	2,040
9 - 11	9,340	3,370	1,640	1,480	630	420	1,800
12 - 14	10,220	3,310	1,790	1,810	1,020	420	1,870
15 - 17	10,770	3,270	1,880	2,080	970	440	2,130
Total	176,610	61,440	26,880	29,310	13,080	7,410	38,490
Rural (Income: >$51,200)							
0 - 2	8,780	3,070	930	1,580	510	450	2,240
3 - 5	9,290	3,040	1,130	1,620	560	420	2,520
6 - 8	9,110	3,040	1,360	1,750	590	450	1,920
9 - 11	8,860	2,910	1,530	1,670	610	460	1,680
12 - 14	9,730	2,840	1,680	2,010	980	470	1,750
15 - 17	10,300	2,810	1,780	2,280	930	490	2,010
Total	168,210	53,130	25,230	32,730	12,540	8,220	36,360

[1] Estimates are for the younger child in a two-child family.

Source: USDA, ARS, Family Economics Research Group. 1993. *Expenditures on a Child by Families, 1992.*

Estimated Annual Expenditures on a Child by Single-Parent Families, Overall United States, 1992[1]

Age of Child	Total	Housing	Food	Transportation	Clothing	Health Care	Education, Child Care, and Other
Income: Less than $32,100							
0 - 2	4,030	1,450	740	1,030	190	100	520
3 - 5	5,110	1,690	770	1,300	270	160	920
6 - 8	5,520	1,930	1,010	1,250	300	170	860
9 - 11	5,840	1,930	1,080	1,370	340	200	920
12 - 14	5,690	1,780	1,220	1,340	640	240	470
15 - 17	6,020	1,890	1,290	1,510	630	220	480
Total	96,630	32,010	18,330	23,400	7,110	3,270	12,510
Income: $32,100 or more							
0 - 2	8,400	3,200	1,110	1,810	290	260	1,730
3 - 5	9,810	3,440	1,210	2,170	380	370	2,240
6 - 8	10,130	3,680	1,490	2,040	420	390	2,110
9 - 11	10,540	3,680	1,690	2,200	460	440	2,070
12 - 14	10,310	3,530	1,800	2,160	840	500	1,480
15 - 17	10,720	3,640	1,870	2,380	830	460	1,540
Total	179,730	63,510	27,510	38,280	9,660	7,260	33,510

[1] Estimates are for the younger child in a two-child family.

Source: USDA, ARS, Family Economics Research Group. 1993. *Expenditures on a Child by Families, 1992.*

Poverty Thresholds

Weighted average poverty thresholds[1] for nonfarm families of specified size, 1965–92

Calendar year	Unrelated individuals			Families of 2 people or more							Annual average CPI, all items (1982–84 = 100)
				2 people			3 people	4 people	5 people	6 people	
	All ages	Under age 65	Age 65 or older	All ages	Householder under age 65	Householder age 65 or older					
1965	$1,582	$1,626	$1,512	$2,048	$2,114	$1,906	$2,514	$3,223	$3,797	$4,264	31.5
1966	1,628	1,674	1,556	2,107	2,175	1,961	2,588	3,317	3,908	4,388	32.5
1967	1,675	1,722	1,600	2,168	2,238	2,017	2,661	3,410	4,019	4,516	33.4
1968	1,748	1,797	1,667	2,262	2,333	2,102	2,774	3,553	4,188	4,706	34.8
1969	1,840	1,893	1,757	2,383	2,458	2,215	2,924	3,743	4,415	4,958	36.7
1970	1,954	2,010	1,861	2,525	2,604	2,348	3,099	3,968	4,680	5,260	38.8
1971	2,040	2,098	1,940	2,633	2,716	2,448	3,229	4,137	4,880	5,489	40.5
1972	2,109	2,168	2,005	2,724	2,808	2,530	3,339	4,275	5,044	5,673	41.8
1973	2,247	2,307	2,130	2,895	2,984	2,688	3,548	4,540	5,358	6,028	44.4
1974	2,495	2,562	2,364	3,211	3,312	2,982	3,936	5,038	5,950	6,699	49.3
1975	2,724	2,797	2,581	3,506	3,617	3,257	4,293	5,500	6,499	7,316	53.8
1976	2,884	2,959	2,730	3,711	3,826	3,445	4,540	5,815	6,876	7,760	56.9
1977	3,075	3,152	2,906	3,951	4,072	3,666	4,833	6,191	7,320	8,261	60.6
1978	3,311	3,392	3,127	4,249	4,383	3,944	5,201	6,662	7,880	8,891	65.2
1979	3,689	3,778	3,479	4,725	4,878	4,390	5,784	7,412	8,775	9,914	72.6
1980	4,190	4,290	3,949	5,363	5,537	4,983	6,565	8,414	9,966	11,269	82.4
1981	4,620	4,729	4,359	5,917	6,111	5,498	7,250	9,287	11,007	12,449	90.9
1982	4,901	5,019	4,626	6,281	6,487	5,836	7,693	9,862	11,684	13,207	96.5
1983	5,061	5,180	4,775	6,483	6,697	6,023	7,938	10,178	12,049	13,630	99.6
1984	5,278	5,400	4,979	6,762	6,983	6,282	8,277	10,609	12,566	14,207	103.9
1985	5,469	5,593	5,156	6,998	7,231	6,503	8,573	10,989	13,007	14,696	107.6
1986	5,572	5,701	5,255	7,138	7,372	6,630	8,737	11,203	13,259	14,986	109.6
1987	5,778	5,909	5,447	7,397	7,641	6,872	9,056	11,611	13,737	15,509	113.6
1988	6,024	6,155	5,674	7,704	7,958	7,158	9,435	12,092	14,305	16,149	118.3
1989	6,311	6,451	5,947	8,076	8,343	7,501	9,885	12,675	14,990	16,921	124.0
1990	6,652	6,800	6,268	8,512	8,794	7,906	10,419	13,360	15,800	17,835	130.7
1991	6,932	7,086	6,532	8,867	9,164	8,238	10,857	13,921	16,457	18,590	136.2
1992[2]	7,141	7,299	6,729	9,132	9,411	8,489	11,187	14,343	16,951	19,146	140.3

[1]The **poverty thresholds** are used by the Bureau of the Census to prepare its statistical estimates of the number of individuals and families in poverty. The **poverty guidelines** are a simplified version of these poverty thresholds and are issued by the Department of Health and Human Services for administrative purposes. The poverty guidelines are used to determine whether a person or family is financially eligible for assistance or services under a particular Federal program.

[2]Preliminary data: 1991 weighted average poverty levels raised by 3.0 percent to correspond with the 1992 increase from the 1991 Consumer Price Index (CPI-U) for all urban consumers.

Cost of Food at Home

Cost of food at home estimated for food plans at four cost levels, May 1993, U.S. average[1]

Sex–age group	Cost for 1 week				Cost for 1 month			
	Thrifty plan	Low-cost plan	Moderate-cost plan	Liberal plan	Thrifty plan	Low-cost plan	Moderate-cost plan	Liberal plan
FAMILIES								
Family of 2:[2]								
20 - 50 years	$51.20	$64.80	$79.80	$99.60	$221.40	$280.60	$345.70	$431.00
51 years and over	48.40	62.40	76.70	91.70	209.80	270.10	332.50	397.50
Family of 4:								
Couple, 20 - 50 years and children—								
1 - 2 and 3 - 5 years	74.30	93.10	113.70	140.00	321.80	403.20	492.60	606.10
6 - 8 and 9 - 11 years	85.10	109.30	136.50	164.70	368.50	473.50	591.60	713.40
INDIVIDUALS[3]								
Child:								
1 - 2 years	13.40	16.40	19.20	23.20	58.10	71.00	83.00	100.50
3 - 5 years	14.40	17.80	22.00	26.30	62.40	77.10	95.30	113.80
6 - 8 years	17.60	23.60	29.50	34.40	76.30	102.20	127.70	149.10
9 - 11 years	21.00	26.80	34.50	39.80	90.90	116.20	149.60	172.50
Male:								
12 - 14 years	21.90	30.40	37.90	44.50	94.80	131.80	164.20	193.00
15 - 19 years	22.60	31.40	39.10	45.30	97.90	136.10	169.30	196.20
20 - 50 years	24.40	31.30	39.00	47.40	105.50	135.70	169.10	205.20
51 years and over	22.10	29.80	36.60	43.90	95.70	129.10	158.70	190.40
Female:								
12 - 19 years	22.00	26.30	32.00	38.70	95.10	114.10	138.60	167.60
20 - 50 years	22.10	27.60	33.50	43.10	95.80	119.40	145.20	186.60
51 years and over	21.90	26.90	33.10	39.50	95.00	116.40	143.60	171.00

[1]Assumes that food for all meals and snacks is purchased at the store and prepared at home. Estimates for the thrifty food plan were computed from quantities of foods published in *Family Economics Review* 1984(*1*). Estimates for the other plans were computed from quantities of foods published in *Family Economics Review* 1983(*2*). The costs of the food plans are estimated by updating prices paid by households surveyed in 1977–78 in USDA's Nationwide Food Consumption Survey. USDA updates these survey prices using information from the Bureau of Labor Statistics, *CPI Detailed Report*, table 4, to estimate the costs for the food plans.

[2]Ten percent added for family size adjustment. See footnote 3.

[3]The costs given are for individuals in 4-person families. For individuals in other size families, the following adjustments are suggested: 1-person—add 20 percent; 2-person—add 10 percent; 3-person—add 5 percent; 5- or 6-person—subtract 5 percent; 7- or more-person—subtract 10 percent.

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Consumer Prices

Consumer Price Index for all urban consumers [1982-84 = 100]

Group	Unadjusted indexes			
	May 1993	March 1993	April 1993	May 1992
All items	144.2	143.6	144.0	139.7
Food	141.1	140.1	140.6	137.4
Food at home	140.7	139.4	140.0	136.2
Food away from home	142.9	142.4	142.7	140.4
Housing	140.5	140.2	140.4	136.7
Shelter	154.9	154.8	155.0	150.2
Renters' costs[1]	164.2	165.2	164.9	159.5
Homeowners' costs[1]	159.4	158.7	159.2	154.4
Household insurance[1]	145.5	144.9	145.2	141.4
Maintenance and repairs	131.6	131.5	131.8	128.1
Maintenance and repair services	135.4	135.8	134.9	131.9
Maintenance and repair commodities	126.6	125.8	127.7	123.0
Fuel and other utilities	120.5	119.5	119.6	116.8
Fuel oil and other household fuel commodities	91.3	92.8	92.6	89.8
Gas (piped) and electricity	117.3	115.1	115.3	113.0
Household furnishings and operation	119.1	118.7	119.2	117.9
Housefurnishings	109.3	109.3	109.7	109.2
Housekeeping supplies	131.3	129.6	130.6	129.5
Housekeeping services	135.1	134.6	135.0	131.0
Apparel and upkeep	135.0	136.2	136.9	133.1
Apparel commodities	132.5	133.9	134.5	130.9
Men's and boys' apparel	128.5	128.7	129.0	127.5
Women's and girls' apparel	134.4	138.4	138.6	132.6
Infants' and toddlers' apparel	127.7	125.9	126.5	130.3
Footwear	127.8	126.3	127.1	126.0
Apparel services	150.9	150.6	150.8	146.8
Transportation	130.2	129.0	129.4	126.3
Private transportation	127.5	126.3	126.8	124.3
New vehicles	132.4	132.0	132.2	129.2
Used cars	131.5	126.6	128.7	120.5
Motor fuel	99.7	97.3	98.4	99.4
Automobile maintenance and repair	145.4	144.7	145.2	140.8
Other private transportation	156.1	156.3	156.1	152.5
Other private transportation commodities	103.5	103.9	103.9	104.8
Other private transportation services	168.2	168.3	168.1	163.2
Public transportation	165.5	163.5	162.8	151.6
Medical care	200.5	198.6	199.4	188.7
Medical care commodities	194.2	193.9	193.7	187.6
Medical care services	202.0	199.7	200.7	188.9
Professional medical services	184.4	182.3	183.0	174.7
Entertainment	145.0	144.8	145.3	142.0
Entertainment commodities	133.0	133.1	133.2	131.2
Entertainment services	159.6	159.0	159.9	155.3
Other goods and services	193.2	192.0	192.4	181.3
Personal care	141.0	140.7	140.6	138.0
Toilet goods and personal care appliances	138.7	138.4	138.1	136.1
Personal care services	143.4	142.9	143.2	139.8
Personal and educational expenses	207.7	206.3	206.7	194.0
School books and supplies	196.1	195.7	195.8	188.4
Personal and educational services	208.8	207.3	207.8	194.7

[1]Indexes on a December 1982 = 100 base.

Source: U.S. Department of Labor, Bureau of Labor Statistics.

Highlights

Elders' Housing Expenditures

Consumer Credit Trends